

SUPERVISION AND COLLABORATION REQUIREMENTS: THE VULNERABILITY OF NURSE PRACTITIONERS AND ITS IMPLICATIONS FOR RETAIL HEALTH

I. INTRODUCTION

Health care is expensive and scarce.¹ These problems will only grow with the recent decline in the number of new physicians pursuing careers as general practitioners, leaving patients competing for fewer available appointment slots.² Faced with reaching the capacity limits associated with the traditional physician-centric primary care model, focus is increasingly shifting toward improving efficiency in the delivery of care, thereby addressing both cost and access concerns.³ One of the most promising avenues for expanding the primary care capacity of the health care system

1. According to government data, health care spending in 2006 exceeded \$2 trillion, an amount which triples the amount spent in 1990 (\$714 billion). Jane An, Romy Saloner, Rebecca Tisdale & Usha Ranji, Kaiser Family Found. *U.S. Health Care Costs: Background Brief*, http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358#1b (last visited May 10, 2010). Health care spending is also growing faster than both inflation and the growth in national income and accounts for approximately 16% of U.S. Gross Domestic Product. *Id.* Out of each dollar of the total \$1.6 trillion spent on health care in 2002, fifty-three cents was spent on hospital care and physician and clinical services. DANA P. GOLDMAN, ELIZABETH A. MCGLYNN & ABBY E. ALPERT, RAND CORP., U.S. HEALTH CARE: FACTS ABOUT COST, ACCESS, AND QUALITY 3, 6 (2005), http://www.rand.org/pubs/corporate_pubs/2005/RAND_CP484.1.pdf. Furthermore, at least one study has shown that American adults receive only approximately half of the recommended medical services considered to be effective in the circumstances according to the literature and the medical community. GOLDMAN, MCGLYNN & ALPERT, *supra*, at 39.

2. According to data from the National Resident Matching Program, compiled by the American Academy of Family Practitioners (AAFP), 2654 residency positions in family practice were offered in 2008, down from the 3262 offered in 1997. American Academy of Family Physician, Table 1—Family Medicine (2009), <http://www.aafp.org/online/en/home/residents/match/table1.html>. Despite this overall decline, it is worth noting that “fill rates” (referring to the percentage of positions offered which were ultimately filled) for family practitioner residency slots have rebounded in recent years after reaching a modern low of just 76.2% in 2003. *Id.* There has been a similar decline in Internal Medicine—Primary Care residency positions, dropping from 608 positions in 1997, to 264 in 2008. American Academy of Family Physicians, Table 7—Internal Medicine (Primary Care) (2009), <http://www.aafp.org/online/en/home/residents/match/table7.html>. See also Elizabeth Harrison Hadley, *Nurses and Prescriptive Authority: A Legal and Economic Analysis*, 15 AM. J.L. & MED. 245, 261–62 (1989) (citing the shortage of primary care physicians due to specialization trend, aging population, and the enactment of Medicare and Medicaid as driving an increase in the demand for health care services, which in turn increased demand for nurses).

3. See William M. Sage, *Might the Fact that 90% of Americans Live Within 15 Miles of a Wal-Mart Help Achieve Universal Health Care?*, 55 U. KAN. L. REV. 1233, 1235–38 (2007) (discussing how the health plan developed by President Clinton primarily focused on insurance and financing reform, whereas recently there has been a shift towards emphasis on health care delivery).

is to look beyond physicians to other categories of health care professionals in order to fill the primary care ranks—namely nurse practitioners (NPs).⁴ In addition to increasing the supply of available primary care, greater utilization of NPs as primary care providers would also achieve cost savings due to lower labor costs associated with nonphysician providers.⁵

This is the foundational concept underlying the rapidly expanding “convenient care” industry: that with a willingness to depart from the traditional physician-centric primary care model, certain categories of care can be administered not only safely by NPs, but also conveniently and inexpensively.⁶ The focal point of the industry are what are known as “retail health clinics” (RHCs),⁷ which are small clinics offering a limited range of basic health services, usually located within large retail stores such as pharmacies and grocery stores.⁸ By staffing the clinics almost

4. Interestingly, many developing countries have turned to mid-level practitioners as a means of addressing significant physician shortages due to high emigration rates of physicians to developed nations, and thus are also faced with the accompanying licensing and scope of practice questions discussed here. See generally Jeffrey P. Lane, *The Need for Effective Licensure Laws for Mid-Level Health Care Providers In Countries Facing Chronic Physician Shortages: A Case Study of the Marshall Islands' Health Assistants*, 17 PAC. RIM L. & POL'Y J. 767 (2008).

5. In 2007, the national average NP salary was \$81,397. Jill Rollet & Sarah Lebo, *2007 Salary Survey Results: A Decade of Growth*, ADVANCE FOR NURSE PRACTITIONERS, Jan. 10, 2008, <http://nurse-practitioners.advancweb.com/Editorial/Content/Editorial.aspx?CC=105177>. In 2007, the mean annual income for a family practitioner was \$161,200. American Academy of Family Physicians, Table 15—Median and Mean 2007 Individual Income Before Taxes of Family Physicians, July 2008, <http://www.aafp.org/online/en/home/aboutus/specialty/facts/15.html>. See also *infra* note 183 (providing data regarding the cost of visits to different care settings).

6. See MARY KATE SCOTT, CAL. HEALTHCARE FOUND., HEALTH CARE IN THE EXPRESS LANE: RETAIL CLINICS GO MAINSTREAM 6 (2007), <http://www.chcf.org/documents/policy/HealthCareInTheExpressLaneRetailClinics2007.pdf> [hereinafter EXPRESS LANE]; Sage, *supra* note 3, at 1241 (discussing increased access due to lower prices).

7. A fundamental distinguishing characteristic of these clinics are expanded weekday hours. Target's clinics are generally open 9 a.m.–8 p.m. Monday through Friday. See Target: Locations, http://sites.target.com/site/en/spot/page.jsp?title=clinic_locations&state=MD (generalized from the hours posted for Target Clinics located in Maryland) (last visited May 10, 2010). Walgreen's TakeCare clinics are generally open 8 a.m.–7:30 p.m. on weekdays, see Find a Take Care Clinic—Take Care Health Centers—Convenient, Affordable Health Care, <http://www.takecarehealth.com/clinic-locations.aspx?region=5> (last visited May 10, 2010) (generalized from the hours posted for Missouri locations), as well as weekend hours (typically 9 a.m.–4 p.m. or 4:30 p.m. both days). See also William M. Sage, *The Wal-Martization of Health Care*, 28 J. LEGAL MED. 503, 505 (2007).

8. The retail stores housing these clinics are known as “host” stores. Jeffery Layne, Christopher N. Kanagawa & India K. Brim, *Retail Health Clinics*, in ENTERPRISE RISK MANAGEMENT HANDBOOK FOR HEALTHCARE ENTITIES 417, 422 (Ellen L. Barton ed., 2009). Current host store chains include pharmacies such as Rite Aid, CVS, and Walgreens; grocery chains such as Kroger and Publix; and “big box” stores such as Target and Wal-Mart. See Convenient Care Association website, <http://www.ccaclinics.org> (last visited May 10, 2010), for a full list of member-run clinics. According to a report by the Convenient Care Association, a retail health trade group, the top ten treatments at Convenient Care Clinics (CCCs) or RHCs are (in order): sore throat, common colds/cold symptoms,

entirely with NPs, RHCs are able to provide wider access at a lower cost.⁹ The potential for utilizing NPs in this independent manner is the culmination of a long, steady evolution of NPs from nurses with advanced training to professionals capable of independent practice.¹⁰ Despite the promise of innovative health care delivery structures possible with independent NP practice, some professionals claim that certain regulatory constraints on NPs in many states keep this potential from being fully realized.¹¹ Web Golinkin, CEO of RediClinic, has been quoted as saying that “[i]f clinics are going to realize their full potential to provide people with easier access to high-quality, routine health care at affordable and transparent prices, some of the regulatory barriers in some states will have to be torn down.”¹²

In addition to the education, accreditation, and licensing requirements faced by most professions, NPs are also subject to a host of additional state-imposed regulations and limitations,¹³ which, despite being framed as safety-based,¹⁴ have the effect of perpetuating the traditional dominance of physicians over all other health care professions.¹⁵ The most common

flu symptoms, cough, sinus infection, allergies, immunizations, and blood pressure testing. Convenient Care Association, *Fact Sheet: Convenient Care Clinics: Physician Oversight*, http://www.ccaclinics.org/images/stories/downloads/factsheets/cca_factsheet_physician_oversight.pdf (last visited May 10, 2010).

9. See Convenient Care Association, *Fact Sheet: Convenient Care Clinics: Reducing Costs for Consumers and Third-Party Payers*, http://www.ccaclinics.org/images/stories/downloads/factsheets/cca_factsheet_affordable_care.pdf (last visited May 10, 2010) [hereinafter Convenient Care Association Fact Sheet] (reporting that the average cost of an emergency room visit as \$445, of a physician visit as \$283, and a visit to an RHC as \$60).

10. See *infra* Part II.

11. See *infra* Part II. For a full discussion of the legal risks involved in operating RHCs, see Layne et al., *supra* note 8, at 417. Among the regulatory issues potentially facing these clinics are the corporate practice of medicine laws, which are still in place in many states, federal and state anti-kickback statutes, HIPAA (Health Insurance Portability and Accountability Act), fee-splitting, and federal Stark laws (anti-self referral). *Id.* at 422–25. Perhaps sparking the most concern thus far is the potential for these clinics to violate Stark laws. *Id.* at 427–28. It may be possible to claim that one of the primary motives driving retailers to locate RHCs in their store is the potential for capturing the pharmacy business of patients who receive prescriptions from the RHC. *Id.* The thought is that if this is the goal, host retail stores will charge the RHC below market rent for the retail space, with some agreement or understanding that the RHC will then refer pharmacy patients to the store’s pharmacy. *Id.* I could not find any report of this, even allegedly, actually occurring as of yet. Furthermore, discussion of this topic is beyond the scope of this Note.

12. See EXPRESS LANE, *supra* note 6, at 12.

13. See *infra* Part II.A.

14. Hadley, *supra* note 2, at 253 (stating that “alleged purpose” of licensure laws “is to assure a minimum quality of care for the consumer . . .”).

15. Peter J. Hammer, *The Architecture of Health Care Markets: Economic Sociology and Antitrust Law*, 7 HOUS. J. HEALTH L. & POL’Y 227, 240 (2007) (“Historically, one cannot think about the architecture of American health care markets without acknowledging the physician’s central

examples of these types of laws are physician supervision or collaboration requirements, corporate practice of medicine prohibitions, and restrictive scope of practice definitions.¹⁶ In states with supervision and collaboration requirements, an NP's authority to practice is conditioned upon some level of physician involvement—usually physician review of a proportion of the NP's charts, physician on-site time requirements, or mandatory collaboration between the NP and a physician in developing detailed care protocols.¹⁷ With the significant gains made by NPs in education, training, and qualifications, the necessity of these requirements in ensuring that NPs provide high quality care comes into question.¹⁸ In light of the reality of modern NP practice, the issue becomes whether these rules do more harm by impeding the evolution towards a more efficient delivery system (including the independent provision of care by NPs) while providing only nominal gains in quality (if any at all).¹⁹

In particular, the persistence of supervision and collaboration requirements must be weighed against the costs of less vigorous competition.²⁰ Independent NPs are generally able to provide basic clinical services²¹ at a lower cost than physicians,²² thereby imposing significant

role.”); *see also infra* note 33 (reciting a traditional definition of nursing which characterized nursing practice as being controlled and supervised by physicians).

16. *See infra* notes 44, 59–62.

17. *See infra* Part II.A.

18. *See Hadley, supra* note 2, at 261–63 (reviewing the modern expansion of nursing practice and the accompanying intensification of training and education requirements); *see also* CAROLYN BUPPERT, NURSE PRACTITIONER'S BUSINESS PRACTICE AND LEGAL GUIDE 47 (3d ed. 2008) (protocols intended to provide a “guideline for a minimum level of safe practice”).

19. *See* Linda H. Aiken & William M. Sage, *Staffing National Health Care Reform: A Role for Advanced Practice Nurses*, 26 AKRON L. REV. 187, 201 (1992) (“Supervision requirements were instituted based on the traditional role of nurses as complementary providers to physicians, but make less sense in the case of nurse practitioners . . . trained specifically to substitute for physicians in certain situations.”).

20. The American Academy of Family Physicians took a slightly more “middle of the road” approach in response to the explosion of RHCs, compared to other physicians groups. In 2006, the group issued a series of recommended guidelines for RHCs. *See* Press Release, American Academy of Family Physicians, America's Family Physicians Urge Retail Health Clinics To Put Patients' Health First (June 22, 2006), <http://www.aafp.org/online/en/home/media/releases/2006/20060622retailhlth.html>. At the same time, the AAFP promoted a new model of care for family physicians, known as “TransforMED” as a means of enhancing their members' ability to compete with RHCs. *See id.* The goal of TransforMED is to increase the availability of same-day service for patients through the concept of “open access scheduling.” *Id.* The AAFP also encouraged physicians to offer expanded office hours. *Id.*

21. By basic clinical services I mean the everyday routine tasks, which are performed in almost all interactions with a health professional (such as taking a patient's history) as well as the commonly confronted ailments and repetitive services required by patients on a regular basis (e.g., suturing, ordering and interpreting simple diagnostic tests, and providing basic information on health maintenance).

22. Hadley, *supra* note 2, at 253.

economic pressures on general practitioners.²³ Additionally, a stream of income for physicians who currently assume supervisory or collaborative roles relative to NPs would be eliminated since such roles generally receive compensation under the current system.²⁴

Although the medical establishment has long opposed NP independence,²⁵ this opposition has further intensified with the advent of innovative, nonphysician based health care delivery structures such as RHCs, which increase the financial viability of NPs as low-cost competitors to physicians in certain categories of care.²⁶ In response to this growth, a number of states have either already imposed, or are considering, legislation specifically regulating RHCs.²⁷ One common thread to much of this legislation are provisions imposing more rigorous NP supervision requirements.²⁸ Intensive collaboration and supervision requirements detract from the vitality of RHCs as a low-cost delivery method capable of increasing access to care by threatening RHC financial viability, because they constitute one of the risks that must be addressed in opening an RHC.²⁹ These requirements add to the cost and complexity of operating RHCs, which are sensitive to cost changes such as these given the already complex environment in which they operate.³⁰

In this Note, I argue that states should eliminate mandatory physician supervision and collaboration requirements for NPs, as they can no longer

23. See Ann Ritter & Tine Hansen-Turton, *The Primary Care Paradigm Shift: An Overview of the State-Level Legal Framework Governing Nurse Practitioner Practice*, 20 HEALTH L. 21, 22 (2008) (“Financial self-interest and concerns about competition may play a role in physicians’ opposition to increased clinical independence for nurse practitioners.”); Hadley, *supra* note 2, at 253.

24. Although I was unable to find a precise salary or industry standard, one RHC company, MinuteClinic, advertises that it pays its Medical Directors “hourly compensation” competitive with the local market of the clinic. See MinuteClinic, Physician Benefits, <http://www.minuteclinic.com/careers/physicians/whatweoffer/> (last visited May 10, 2010).

25. See Susan E. Baker, *The Nurse Practitioner in Malpractice Actions: Standard of Care and Theory of Liability*, 2 HEALTH MATRIX 325, 333–34 (1992) (quoting a representative of the AMA: “We do not believe in the concept of independent physician extenders. We believe they should be dependent and supervised . . . I believe that you maintain control by maintaining control of the money”).

26. See Ritter & Hansen-Turton, *supra* note 23, at 22; see also *infra* notes 67, 70–72, 75 and accompanying text for a discussion of recent state-level legislative and judicial moves against NPs.

27. See *infra* notes 67, 70–72.

28. See *infra* notes 67, 70–72.

29. See also Layne et al., *supra* note 8, at 425–27. The impact of these laws is observable as RHCs “have expanded most rapidly in states that allow broader scope of practice to non-physicians.” Sage, *supra* note 3, at 1238.

30. See Sage, *supra* note 7, at 518 (characterizing the risk that retail clinics will be unable to reach financially viable methods of pairing the needs of patients with the “resources of appropriate health care providers” as “substantial”); see also EXPRESS LANE, *supra* note 6, at 21 (describing the economics of an RHC company as “challenging”).

be justified in light of the status of modern NP qualifications and practice, and may be used to stifle valuable innovation. In Part II, I review the history of the NP profession and the basic legal framework in which NPs practice. I also survey and scrutinize the ways in which these laws are being used to restrain the economic competitiveness of NPs. In Part III, I examine the ways in which supervision and collaboration mandates impact malpractice liability mechanisms and the consequences of these distortions. In Part III, I also analyze malpractice tort theories available under a regime of independent practice by NPs, arguing that these theories are sufficient to satisfy the goals of malpractice law. In Part IV, I discuss the policy implications of allowing these types of requirements to persist, with particular focus on the promise of market-based solutions centered on NPs to the access and cost problems plaguing the health care system. Finally, in Part V, I offer my brief conclusions on these issues, advocating full statutory independent practice for NPs.

II. BACKGROUND

NPs³¹ have been defined as “registered nurses who are prepared, through advance education and clinical training, to provide a wide range of preventive and acute health care services to individuals of all ages.”³² This is in contrast to the purely complementary role nurses have traditionally occupied in relation to primary care administered by physicians.³³ Connecticut was among the first states to pass a mandatory licensure law for nurses in 1939, defining the practice of nursing as the performance of certain acts “under the direction of a licensed physician.”³⁴ In contrast, NPs are “registered nurses who qualify,” and are licensed, “for advanced nursing practice by receiving a postgraduate education.”³⁵ Since the profession was established, NPs have emerged and evolved into a

31. The term “nurse practitioner” is sometimes used interchangeably with the term “advanced-practice nurse.” See BUPPERT, *supra* note 18, at 2. The term “advanced practice nurse” is actually an umbrella term which covers a wide variety of nursing distinctions, namely NPs, clinical nurse specialists, nurse midwives, and nurse anesthetists (CRNAs). See *id.* at 3.

32. *Id.* at 1.

33. See Hadley, *supra* note 2, at 250 (describing nurses as complements to physician services under the first nurse licensure laws because they usually defined nursing as “the performance of certain functions under the supervision of a physician”).

34. *Id.* at 256. Connecticut passed its law in 1939, one year after New York. See *id.*

35. See Baker, *supra* note 25, at 325. For an example of a state’s definition, see *Siegel v. Husak*, 943 So. 2d 209, 211 (Fla. Dist. Ct. App. 2006) (defining Florida’s statutory equivalent of NPs as “registered nurses who have achieved further training and certification, after which they can perform additional supervised medical procedures and tasks that normally cannot be lawfully performed by other types of licensed nurses”).

licensed, well-educated, rigorously trained category of health professionals with an expansive skill set, enabling them to function on a largely independent basis.³⁶

The NP concept gained traction in the late 1960s as part of a more general expansion of the nursing profession.³⁷ The cornerstone of NPs, as distinct from the more common “registered nurse,”³⁸ is that NPs are generally viewed as qualified to undertake more sophisticated and specialized acts than traditional registered nurses, much of that care requiring the exercise of independent clinical judgment.³⁹ In general, the tasks commonly performed by NPs range from more traditional clinical activities, such as taking patient histories, providing immunizations, and ordering lab tests and interpreting their results, to more holistic forms of care including educating patients about illnesses and health risks, and assisting in the coordination of care.⁴⁰ NPs offer an alternative source of more basic forms of care that patients previously sought from a

36. See BUPPERT, *supra* note 18, at 3. Forty-six states currently require NPs to be certified. Lyndia Flanagan, *Nurse Practitioners: Growing Competition for Family Physicians?*, FAM. PRAC. MGMT., Oct. 1998, available at <http://www.aafp.org/fpm/981000fm/nurse.html>. “A state requirement that an NP be nationally certified leads to a requirement of master’s education because the certifying agencies . . . require a master’s degree to sit for the certification examination.” BUPPERT, *supra* note 18, at 5; see also National Council of State Boards of Nursing, Boards of Nursing, <https://www.ncsbn.org/boards.htm> (last visited May 10, 2010) (“Each state or territory has a law called the Nurse Practice Act which is enforced by each nursing board. Nurses must comply with the law and related rules in order to maintain their licenses. The law describes . . . [q]ualifications for licensure . . .”). Carolyn Buppert provides the following list of the primary and typical functions of NPs:

Obtaining medical histories and performing physical examinations[,] [d]iagnosing and treating health problems[,] [o]rdering and interpreting laboratory tests and X-rays[,] [p]rescribing medications and other treatments[,] [p]roviding prenatal care and family planning services[,] [p]roviding well-child care and immunizations[,] [p]roviding gynecologic examinations and Pap smears, providing education about health risks, illness prevention, and health maintenance[,] [c]ase management and coordination of care[.]

BUPPERT, *supra* note 18, at 3. The first NP program was established at the University of Colorado in 1965. See Baker, *supra* note 25, at 327.

37. See BUPPERT, *supra* note 18, at 6–7.

38. A registered nurse is “a nurse who has graduated from an accredited nursing program, has passed the state examination for licensure, and has been registered and licensed to practice by a state authority.” STEDMAN’S MEDICAL DICTIONARY (28th ed. 2006).

39. See BUPPERT, *supra* note 18, at 7 (first emerged when some states chose to expand their nurse practice acts scope of practice provision to “allow diagnosis and treatment by nurses”). Buppert states that as the concept of the NP evolved, it was intended that they make both nursing and medical diagnoses. *Id.* NPs are also becoming increasingly specialized in specific fields. According to the American Academy of Nurse Practitioners, NPs specialize in areas including family health, neonatal health, women’s health, and mental health with many practicing in sub-specialties including pulmonology, dermatology, and emergency care. See American Association of Nurse Practitioners, FAQs about NPs, <http://www.aanp.org/AANPCMS2/AboutAANP/About+NPs.htm> (last visited May 10, 2010).

40. See BUPPERT, *supra* note 18, at 4.

physician.⁴¹ As the range of care offered by NPs has expanded, NPs have become more controversial, as many general and family practitioners contend that these basic forms of primary care are essential to supporting their practices.⁴²

Today, a complex network of rules and regulations has developed from both governmental and nongovernmental sources, which frames the environment in which NPs practice. In Part A of this section, I survey the current legal framework in which NPs practice, with particular emphasis on physician supervision and collaboration regulatory regimes. In Part B, I identify and analyze recent state-level proposals to intensify existing physician supervision and collaboration requirements for NPs and the context in which these proposals are arising.

A. Current Legal Framework

The NP profession is rigorously regulated and monitored—both through governmental restrictions and statutes limiting scope of practice, creating education and accreditation requirements, and mandating licensure; there is also significant self-governing by the profession itself through private accrediting agencies and NP and nursing associations.⁴³ The primary source of rules governing NP practice are state Nurse Practice Acts and related regulations.⁴⁴ Similar to statutes relating to other

41. See *supra* note 36 for a description of the types of care that NPs are generally considered qualified to provide.

42. See Rahul K. Parikh, *Wal-Mart Can Be Good for Your Health*, SALON, Feb. 19, 2008, http://www.salon.com/mwt/feature/2008/02/19/retail_health_clinics/.

43. See *infra* notes 45–49. There are several organizations that accredit nursing education programs, including the National League for Nursing Accrediting Commission and the American Nurses Credentialing Center. Other organizations, including the American Nurses Association, the American Academy of Nurse Practitioners, and the American Association of Nurse Anesthetists, also offer certification programs for nurses.

44. BUPPERT, *supra* note 18, at 37–38, 51; see also Ritter & Hansen-Turton, *supra* note 23, at 23 (“While some federal laws, such as those regarding Medicaid and Medicare providers, have an impact on nurse practitioner practice, all laws and regulations governing nurse practitioners’ scope of practice, licensure, and physician collaboration requirements are created and enforced at the state level.”). The efficiency of scope of practice laws has been a source of vigorous debate. See Alison M. Sulentic, *Crossing Borders: The Licensure of Interstate Telemedicine Practitioners*, 25 J. LEGIS. 1, 8 n.50 (1999). Commentators looking specifically at nursing scope of practice statutes have been particularly critical of what they perceive as the vagueness of the definitions of permissible practice used in these statutes. See, e.g., Baker, *supra* note 25, at 339 (quote *infra* note 45); Janette A. Bertness, *Rhode Island Nurse Practitioners: Are They Legally Practicing Medicine Without A License?*, 14 ROGER WILLIAMS U. L. REV. 215, 255–59 (2009) (criticizing the vagueness of the Rhode Island NP scope of practice statute); BUPPERT, *supra* note 18, at 38 (“[A] vaguely worded nurse practice act that states, for example, that the scope of NP practice includes ‘acts of advanced nursing practice’ will not provide sound legal basis for arguments that NPs should be admitted to managed care provider panels or get fees for providing physician services.”); MINN. STAT. § 148.171(11) (2009) (defining nurse

professions, these laws usually define the categories of nurses authorized to practice in the state and set forth basic conditions for obtaining a license to practice as an NP in the state—including education and accreditation requirements.⁴⁵ Even in states not expressly stating specific education requirements, national accreditation organizations such as the American Nurses Credentialing Center, generally require individuals to hold a masters, post-masters, or doctorate from an approved nurse practitioner program in order to be eligible to sit for the national accreditation exam.⁴⁶ Finally, Nurse Practice Acts also define the legal contours and limits of practice for each category of nurse authorized under the statute—what is known as “scope of practice.”⁴⁷

These Acts typically authorize the state nursing board to establish rules regarding nursing practice, along with a corresponding power to take administrative action against noncompliant nurses.⁴⁸ States vary as to which state entity has the power to impose regulations impacting NPs and their practice.⁴⁹ The broad approach taken in defining authorized NP

practitioner practice as “within the context of collaborative management: (1) diagnosing, directly managing, and preventing acute and chronic illness and disease; and (2) promoting wellness, including providing nonpharmacologic treatment”).

45. See, e.g., CAL. BUS. & PROF. CODE § 2835.5(d)(2)–(3) (West 2003) (requiring that NP hold a master’s degree in nursing or other clinical field related to nursing, and must complete an approved NP program); OHIO REV. CODE ANN. § 4723.42(B)(2) (West 2004) (condition of license renewal that NP provide documentation of continued certification “in the nursing specialty with a national certifying organization”).

46. See American Nurses Credentialing Center, Family Nurse Practitioner Certification Eligibility Criteria, <http://www.nursecredentialing.org/Eligibility/FamilyNPEligibility.aspx> (last visited May 10, 2010).

47. Baker, *supra* note 25, at 338.

48. *Id.* at 338–39.

49. See BUPPERT, *supra* note 18, at 126–28. In some states, the Board of Nursing has the exclusive authority to impose regulations for NPs; while in others, the authority rests in a joint board of nurses and physicians. *Id.* For an example of a state which delegates exclusive authority to the board of nursing, see OR. REV. STAT. § 678.140 (2008) (detailing the composition of the nine-member board—five registered nurses, two licensed practical nurses, and two members of the public), and OR. REV. STAT. § 678.380 (2008) (delegating to the Oregon State Board of Nursing the authority to “adopt rules applicable to” NPs, which establish certification requirements, limit or restrict practice, define scope of practice, etc.). For an example of a state creating joint boards of physicians and nurses in which this authority is vested, see MD. CODE ANN., HEALTH OCC. § 8-205(a)(3) (LexisNexis 2009) (granting authority to the Board of Nursing “[t]o adopt rules and regulations for the performance of delegated medical functions which are recognized jointly by the State Board of Physicians and the State Board of Nursing”); and MD. CODE ANN., HEALTH OCC. § 14-306(d)(1) (LexisNexis 2009) (“If a duty that is to be delegated under this section is a part of the practice of a health occupation that is regulated under this article by another board, any rule or regulation concerning that duty shall be adopted jointly by the Board of Physicians and the board that regulates the other health occupation.”).

Still others give primary authority to the Board of Nursing but also provide the state medical board with a limited ability to create regulations which have a direct impact on NPs. Georgia is a prime example of this. See GA. CODE ANN. § 43-34-26.1 (2009) (granting authority and enforcement

practice is a double-edged sword—it allows flexibility and expansion as NPs become qualified to take on additional activities, but makes such an expansion a risk for NPs (and their employers or supervising physicians), since the statutes fail to expressly authorize particular types of care.⁵⁰ In the event that NPs are deemed to have overstepped the bounds of authorized practice, they are subject to sanction by professional disciplinary boards, and may even face revocation of their licenses.⁵¹ NPs may also be subject to sanction by state medical boards for exceeding their scope of practice if such activity is viewed as crossing the line into “practicing medicine,” which is typically prohibited by any individual or other professional not possessing a license to practice medicine in the state.⁵² Although not providing for compensation of injured victims, licensure-based sanctions are prophylactic in a way because injury to a patient need not be shown, and therefore may catch risky conduct before it results in actual injury.⁵³ While licensure-based discipline is commonly available for licensed professions, NPs also face categories of regulation

power to the State Board of Medical Examiners to promulgate rules regarding the delegation of activities to nurses, physician assistants, and NPs).

50. See Ritter & Hansen-Turton, *supra* note 23, at 23–24 (“This typically expansive definition of nurse practitioner scope of practice allows nurse practitioners to provide comprehensive primary care to a wide range of patients that ‘can both substitute for and complement the care of physicians.’”) (citation omitted). *But see* Baker, *supra* note 25, at 339 (“Failure to define the boundaries of practice may restrict instead of expand the scope of practice by causing hesitancy among NPs to expand their role for fear of malpractice actions or actions from the physician community charging them with practicing medicine.”).

51. At least one commentator has criticized the fact that licensing boards are not required to have an empirical basis for limiting the practice of one category of professional compared to another, advocating that such limits should be based on comparative empirical risk assessment. See BARRY R. FURROW, THOMAS L. GREANY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS JOST & ROBERT L. SCHWARTZ, *HEALTH LAW* 73 (2d ed. 2000) (citing Sandra H. Johnson, *Regulatory Theory and Prospective Risk Assessment in the Limitation of Scope of Practice*, 4 J. LEGAL MED. 447, 447 (1983)).

52. See *Yancy v. United Surgical Partners Int’l, Inc.*, 170 S.W.3d 185, 191 (Tex. App. 2005) (“[A]s a matter of statutory regulation, nurses are prohibited from making any type of medical diagnosis.”). This is a major source of potential liability due to the broad definition of “practicing medicine” that many states employ. See, e.g., MONT. CODE ANN. § 37-3-102(8) (2009) (defining the practice of medicine as “the diagnosis, treatment, or correction of or the attempt to or the holding of oneself out as being able to diagnose, treat, or correct human conditions, ailments, diseases, injuries, or infirmities, whether physical or mental, by any means, methods, devices or instrumentalities”). In response, some states specifically exempt nurses rendering services in lawful discharge of their duties from coverage by their Medical Practice Acts to ameliorate the possibility of overlap. See, e.g., MONT. CODE ANN. § 37-3-103(1)(i); N.C. GEN. STAT. ANN. § 90-18(c)(14) (West 2008).

53. FURROW ET AL., *supra* note 51, at 75 (“Although protection of the public health provides the rationale for licensure, disciplinary actions under the licensing statutes do not require that injury to any particular patients be proven.”); see also *Britt v. Dep’t of Prof’l Regulation*, 492 So. 2d 697, 698 (Fla. Dist. Ct. App. 1986).

that apply exclusively to NPs—namely those that require and define the relationship between a physician and an NP.⁵⁴

Although not all states impose them,⁵⁵ physician supervision and collaboration requirements are perhaps the most distinctive forms of regulation governing NPs in many states. Compared to the relatively standard nature of NP scope of practice statutes from state to state, collaboration and supervision statutory schemes are notorious for varying widely.⁵⁶ The traditional formulation consists of a requirement that an NP work in conjunction with a physician to develop a written protocol under which the NP practices.⁵⁷ Additionally, there are two primary types of mechanisms used most often in supervision and collaboration schemes: on-site time requirements and chart-review requirements.⁵⁸ On-site provisions require that a supervising or collaborating physician spend some minimum amount of time at the location at which the NP practices, on some regular basis.⁵⁹ As you might expect, chart-review provisions require a supervising or collaborating physician to review a certain portion of the NPs patient charts on a regular basis.⁶⁰ A number of states requiring

54. See *infra* notes 59–62, 64.

55. Eight states currently do not mandate any physician involvement in NP Practice: Alaska, Idaho, Maine, New Hampshire, New Mexico, Oregon, Utah, and Washington. BUPPERT, *supra* note 18, at 46. Michigan also does not mandate physician involvement, though it is arguably distinctive from the others since there is no statute currently on the books regarding scope of practice. *Id.*

56. Ritter & Hansen-Turton, *supra* note 23, at 24 (“Legal requirements regarding the relationship between nurse practitioners and physicians lack standardization.”). It is also worth noting that what constitutes “supervision” in one state may be more akin to “collaboration” in another state. *Id.*; see also *infra* notes 59–62 and accompanying discussion.

57. *Id.* at 24.

58. Baker, *supra* note 25, at 24.

59. Seven states currently have on-site supervision requirements. Ritter & Hansen-Turton, *supra* note 23, at 25 Tbl. 1; see ALA. ADMIN. CODE r. 610-X-5-.08(4) (2007) (physician must be present for at least 10% of NP’s scheduled hours); ILL. ADMIN. CODE tit. 68, § 1305.35(a)(2) (2007) (physician must be present onsite at least once a month) (there is a proposed repealer being considered currently); MO. CODE REGS. ANN. tit. 20, § 2150-5.100(4)(B) to (C) (2009) (NP must practice at least once every two weeks at the same site as physician prior to practicing at a location apart from collaborating physician); S.D. ADMIN. R. 20:62:03:01 (2007) (direct personal contact no less than half a day a week or one hour per ten hours of practice); TENN. COMP. R. & REGS. 0880-6-.02(9) (2007) (physician must visit remote site once every thirty days); TEX. OCC. CODE ANN. § 157.0541(c)(1) (Vernon 2004) (physician must be on-site at least 20% of the time).

60. Five states currently impose chart review requirements. Ritter & Hansen-Turton, *supra* note 23, at 25 Tbl. 2; see ALA. ADMIN. CODE r. 610-X-5-.08(9)(g) (2007) (physician must review no less than 10% of medical records plus all adverse outcomes); GA. COMP. R. & REGS. 360-32-.02(7)(b)-(c) (2007) (must review and sign 100% of records with adverse outcome within thirty days and 10% of all other records at least annually); MONT. ADMIN. R. 24.159.1466(2)(a) (2006) (requiring NP to have a quality assurance method involving review of fifteen charts or 5% of all charts that the NP reviewed quarterly); TENN. COMP. R. & REGS. 0880-6-.02(8) (2007) (must review at least 20% of charts every thirty days); TEX. OCC. CODE ANN. § 157.0541(c)(2) (Vernon 2004) (physician must review at least 10% of charts).

a physician's supervision or collaboration also mandate that the physician practice within a certain maximum geographic distance of the NP's practice location.⁶¹ Many states also impose "maximum oversight ratios" that prohibit physicians from collaborating with or supervising more than a certain number of NPs at one time.⁶²

Physician supervision and collaboration requirements carry significant implications for NP practice. Under physician supervision and collaboration regimes, physicians are placed in a position to effectively exercise control over both the scope of practice of NPs and the financial viability of the NP's practice.⁶³ Pursuant to these requirements, an NP is only allowed to provide those forms of care which the physician consents to include in the requisite written protocol guiding the NP's practice.⁶⁴ By requiring an NP to seek the approval and consent of a physician prior to providing a new type of care, or in any other way departing from the previously established written protocol, NPs are rendered dependent and subordinate to physicians.⁶⁵ Additionally, maintenance of a supervisory or collaborative relationship with a physician can add significantly to the labor costs associated with NP practice.⁶⁶ States with maximum NP-to-

61. See, e.g., MO. CODE REGS. ANN. tit. 20, § 2150-5.100(2)(B) (2009) (NP must generally practice within thirty miles of collaborating physician, fifty miles if the NP is practicing in a federally designated shortage area); 18 VA. ADMIN. CODE § 90-40-100(B) (2008) (NP may not practice in separate setting from physician).

62. 18 VA. ADMIN. CODE § 90-40-100(A) (2008) (physician may supervise no more than four NPs at any given time). Texas has one of the most stringent statutory schemes governing NP practice—incorporating physician on-site and availability requirements, collaboration provisions, and maximum supervision ratios. TEX. OCC. CODE ANN. § 157.0541 (Vernon 2004) (required level of supervision includes developing a protocol, working onsite with the APN 20% of the time, reviewing at least 10% of the APN's charts, and being available via direct telecommunication for consultation, referral, or emergency; physician may not delegate to or supervise more than three PAs or APNs, or their full-time equivalents).

63. See Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417, 452 (1992) ("An MD's decision to enter into a direction/supervision agreement with an APN is governed by no identifiable objective standards and limited by no procedural guarantees. Thus, the APN's ability to practice under her license . . . turns ultimately upon one private individual's 'willingness.'").

64. *Id.*; see also, e.g., FLA. ADMIN. CODE ANN. r. 64B9-4.010(1) (2009) ("An Advanced Registered Nurse Practitioner shall only perform medical acts of diagnosis, treatment, and operation pursuant to a protocol between the ARNP and a Florida-licensed medical doctor, osteopathic physician, or dentist."); FLA. STAT. § 464.012(3) (2007) ("An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board . . . within 30 days after entering into a supervisory relationship with a physician . . .").

65. Barbara Safriet has argued that these regulations essentially "mandate a life-long apprenticeship" because "no matter how skilled and experienced the APN, or how utterly inexperienced the MD, physician oversight is a statutorily imposed condition of competence for APN practice." Safriet, *supra* note 63, at 452.

66. Although compensation schemes vary widely, it is standard industry practice for physicians

physician oversight ratios magnify this additional cost since any clinic employing greater than the threshold number of NPs would need to hire multiple physicians to oversee the NPs in that one clinic.⁶⁷ Because of the significant cost implications associated with supervision and collaboration requirements, such requirements leave NPs vulnerable to manipulations of the economic viability of their profession.⁶⁸ A compelling indicator of the significance of these laws is the prevalence of recent proposals to intensify these requirements in response to the burgeoning popularity of RHCs and their utilization of NPs as the primary providers of care in RHCs.⁶⁹

B. Recent State-Level Attacks on NPs in Response to RHCs

Recent state-level attacks on NPs provide stark evidence of the current vulnerability of the NP profession. Coinciding with the rapid expansion of RHCs across the country, a number of states have taken up legislative proposals to regulate RHCs and the NPs who staff them.⁷⁰ These proposals

to receive payment in some form for filling this role. See Carolyn Zaumeyer, *Finding a Physician Collaborator*, ADVANCE FOR NURSE PRACTITIONERS, <http://nurse-practitioners.advanceweb.com/Editorial/Content/Editorial.aspx?CC=35707> (last visited May 10, 2010) (“Some NPs pay their collaborating physicians a flat monthly fee. Others base their payment on the number of charts reviewed. Some even base their payments on a percentage of their revenue.”).

67. See Letter from Maureen K. Ohlhausen, Dir., Office of Policy Planning, Fed. Trade Comm’n, to the Hon. Elaine Nekritz, Ill. State Rep., 7 (May 29, 2008), available at <http://www.ftc.gov/os/2008/06/V0800113letter.pdf> [hereinafter Ohlhausen Letter] (stating “such special requirements could potentially restrict competition, as they might tend to suppress supply or raise prices without conveying countervailing benefits,” referring to a proposal to implement a two-clinic limit on medical directors, likening it to a limit on the number of NPs a physician could collaborate with); see also *supra* note 24 (RHC compensation to medical directors).

68. This control could be said to exist on two levels: (1) through practically requiring payments to the supervising or collaborating physician, see *MinuteClinic*, *supra* note 24, Zaumeyer, *supra* note 66; and (2) by effectively controlling the services an NP can offer to their patient-consumers through controlling the content of the supervision/collaboration protocol, see *supra* note 63 and accompanying text.

69. See *infra* Part II.B. These state-level proposals show the significance of these laws because they indicate that manipulation of these rules provide a ready tool by which the prospects of this promising innovation can be altered.

70. Richard Cauchi, Nat’l Conference of State Legislatures, *Retail Health Clinics: State Legislation and Laws*, Nov. 2009, <http://www.ncsl.org/default.aspx?tabid=13959>. According to the National Conference of State Legislatures, other states which considered legislative action related to RHCs from 2007–08 include the following: FLA. STAT. § 456.041 (2007) (prohibiting physicians from supervising more than one office facility and supervising more than four PAs or NPs at any given time); H.B. 1484, 160th Session (N.H. 2008) (establishing a commission to study and develop legislation to regulate the operation of RHCs) (signed into law); S.B. 1256, 2007–2008 session (N.C. 2007) (would provide for a legislative study of RHCs) (did not pass); S.B. 1523, 2008 session (Okla. 2008) (proposing certain scope of practice limits and supervision of RHCs) (did not pass) and S.B. 1638, 2008 session (Okla. 2008) (proposing “supervision of non-physician practitioners in certain circumstances”) (did not pass); H.B. 1096, 80th Reg. Sess. (Tex. 2007) (relating to “the delegation of

have taken a number of forms, both legislative and administrative, and have taken aim at several issues at the heart of NP practice.⁷¹ Many of these proposals include provisions to modify physician supervision and collaboration requirements, either for NPs in general, or specifically for NPs practicing in retail settings.⁷² While states undoubtedly possess the power to regulate NP practice,⁷³ these proposals carry the specter of anticompetitive motives due to their potential impact on the RHC industry.⁷⁴

The Federal Trade Commission (FTC) has expressed reservations towards special NP oversight rules for RHCs in response to Illinois House Bill 5372, which contained a provision stating that “[a] physician may be a medical director of no more than 2” RHC facilities.⁷⁵ The FTC posited that this “two-clinic limit could be read to impose special supervisory requirements on licensed advanced practice nurses when those nurses provide limited health care services in a retail setting.”⁷⁶ The FTC went on to describe the basis for imposing “special supervisory burdens” on RHCs as unclear since such burdens “could potentially restrict competition, as

certain medical acts by a physician to an advanced practice nurse or physician assistant”) (did not pass). *Id.*

71. See generally Jennifer Ford, *Annual Legislative Update*, ADVANCE FOR NURSE PRACTITIONERS, Dec. 2008, <http://nurse-practitioners.advanceweb.com/Editorial/Content/Editorial.aspx?CC=190736>. For example, bills have been proposed in a number of states which call for removing recognition of the NP profession from under the umbrella of the Board of Nursing and transferring authority to the Board of Medicine. *Id.* There have also been recent attempts in Oklahoma and New Mexico to remove NPs from the authority of the state nursing board. *Id.* The Oklahoma bill, which failed, would have transferred authority over NPs from the board of nursing to the Board of Medical Licensure and Supervision. *Id.* The proposed bill in New Mexico would create a “Super Board,” composed predominantly of physicians, “to oversee any changes in scope of practice for all health care professions.” *Id.* Another target has been modifying administrative rules governing the permitted scope of NP practice. For instance, in West Virginia, the Board of Medicine is currently contemplating a rule change that would expand the definition of the practice of medicine to include even simple, minor treatments involving manipulation of skin below its outermost layer. *Id.* The text of the proposed rule is available on the West Virginia Board of Medicine’s website at http://www.wvbom.wv.gov/prop_csr_11_10.asp (would include deep ablative, ablative, and non-ablative treatments and the alteration of the tissue by any mechanical means in the definition of the practice of medicine and surgery and would require delegation of the authority to perform such tasks by a supervising physician). Such a change could preclude NPs from activities such as stitching wounds—activities that NPs have traditionally performed. *Id.* See also *supra* note 70 (statutes and proposed bills).

72. See *supra* note 70 (Florida and Oklahoma legislation); see also Ohlhausen, *supra* note 67.

73. See Ritter & Hansen-Turton, *supra* note 23, at 23.

74. See *supra* notes 12, 67; *infra* note 165.

75. Ohlhausen Letter, *supra* note 67, at 6. The bill also included a provision prohibiting an RHC from being located “in any store or place that provides alcohol or tobacco products for sale to the public,” which drew significant criticism from the FTC. *Id.* at 10–11; see also H.B. 5372, 95th Gen. Assem. (Ill. 2008).

76. Ohlhausen Letter, *supra* note 67, at 6.

they might tend to suppress supply or raise prices without conveying countervailing benefits to Illinois health care consumers.”⁷⁷ While the FTC gave a less than enthusiastic response to enhanced supervision and collaboration requirements that only would apply to NPs practicing in RHCs, this does not address the possibility of legislation imposing increased oversight requirements on all NPs as a means of achieving the same ends.

III. IMPACT OF SUPERVISION AND COLLABORATION REQUIREMENTS ON MALPRACTICE LIABILITY

Supervision and collaboration requirements implicate a question that has long perplexed both courts and legislatures: when should one professional be held liable for the negligent actions of another professional?⁷⁸ NP malpractice is governed under the laws of negligence,⁷⁹ where a victim must show that the defendant professional failed to act in a manner consistent with the professional standards of acceptable practice and that the failure to do so resulted in harm to the victim.⁸⁰ Traditionally, courts applied theories of *respondeat superior* and vicarious liability to hold physicians liable.⁸¹ Through *respondeat superior*, an employer or principal may be held liable for the “employee’s or agent’s wrongful acts

77. *Id.* at 7.

78. *See, e.g.*, *Southland Constr., Inc. v. Richeson Corp.*, 642 So. 2d 5, 9 (Fla. Dist. Ct. App. 1994) (in context of engineer liability, discussing Florida professional service corporation statute Sections 621.07 and 471.023(3), which states that an “officer, agent, or employee of a corporation shall be personally liable and accountable” for both negligent acts committed by him, as well as such acts committed by “any person under his direct supervision and control, while rendering professional services on behalf of the corporation”); *Parker v. Freilich*, 803 A.2d 738, 748 (Pa. Super. Ct. 2002) (holding physician liable under theory of ostensible agency for negligence of doctor’s independent contractor anesthetist); *Prosize v. Foster*, 544 S.E.2d 331, 332–34 (Va. 2001) (looking at liability of attending physician for negligence of medical resident under her supervision using theory of *respondeat superior*); *Estep v. Hamilton*, 201 P.3d 331, 337 (Wash. Ct. App. 2008) (claim alleged legal malpractice against attorney and vicarious liability of that attorney’s law partners at the time under theory of apparent authority).

79. *Baker, supra* note 25, at 343.

80. Requirements for establishing medical malpractice claims are usually set forth in state statutes. *See, e.g.*, TENN. CODE ANN. § 29-26-115 (2000).

81. *Baker, supra* note 25, at 344. General agency theory potentially applies to physicians because physicians who incorporate NPs into their practice could be said to be conducting their practice through the NPs, which is sufficient for agency liability under the RESTATEMENT (THIRD) OF AGENCY § 7.05 (2006).

According to the RESTATEMENT (THIRD) OF AGENCY § 2.04 (2006): “An employer is subject to liability for torts committed by employees while acting within the scope of their employment.” It is also worth noting that *respondeat superior* liability and vicarious liability on the basis of agency are two separate doctrines. *See Rogers v. J.B. Hunt Transport, Inc.*, 649 N.W.2d 23, 28–29 (Mich. 2002) (Kelly, J., dissenting).

committed within the scope of the employment or agency.”⁸² The applicability of the doctrine of *respondeat superior* turns on whether the person employing the employee or agent has the right to control the conduct of the employed person in the performance of the services.⁸³ These theories were well suited to traditional nursing practice where nurses are generally viewed as being entirely dependent on physicians in providing care.⁸⁴ In such circumstances the control test was easily met.⁸⁵ As modern NPs increasingly engage in nonemployment relationships with physicians and practice in a more independent fashion, it becomes more difficult to establish the requisite level of control necessary to apply vicarious liability theories to hold physicians liable.⁸⁶ This is further complicated by uncertainty as to the significance of supervision and collaboration requirements with regard to whether a physician had the right to control the actions of an NP under such an arrangement.⁸⁷

Courts look at many factors in determining whether the requisite right of control is present. Among the factors suggested by the *Restatement (Third) of Agency* are: (1) the “extent of control” granted to the principal under the terms of the agreement; and (2) “the skill required in the agent’s occupation.”⁸⁸ There is support for the conclusion that the protocols required under supervision and collaboration regimes provide a sufficient

82. BLACK’S LAW DICTIONARY 1338 (8th ed. 2004).

83. RESTATEMENT (THIRD) OF AGENCY § 7.03 cmt. d(2) (2006); *see also, e.g.*, *Kashishian v. Port*, 481 N.W.2d 277, 280 (Wis. 1992) (“The right to control is the dominant test in determining whether an individual is a servant.”) (citation omitted); *Pamperin v. Trinity Mem’l Hosp.*, 423 N.W.2d 848, 852 (Wis. 1988) (hospital did not exercise right to control manner in which independent contractor radiologist provided professional services); *Diggs v. Novant Health, Inc.*, 628 S.E.2d 851, 857–58 (N.C. Ct. App. 2006) (hospital had no right to control manner or method of anesthesiology work at hospital by anesthesiologist and nurse). *But cf.* *Berel v. HCA Health Servs. of Tex., Inc.*, 881 S.W.2d 21, 24 (Tex. App. 1991) (fact that hospital employed a quality assurance person who reviewed charts to assure adequate patient care was sufficient to raise question of fact as to whether hospital exercised right to control physician). For a classic definition of the doctrine of *respondeat superior*, see *Phila. & Reading R.R. Co. v. Derby*, 55 U.S. 468, 486 (1852) (defining the rule of *respondeat superior* as being “that the master shall be civilly liable for the tortious acts of his servant . . . whether the act be one of omission or commission, whether negligent, fraudulent, or deceitful”).

84. William O. Morris, *The Negligent Nurse-The Physician and the Hospital*, 33 BAYLOR L. REV. 109, 122 (1981) (“A nurse, however, is not permitted to exercise broad judgment in diagnosing or treating symptoms that the patient may develop. The nurse’s duty is to report such symptoms to the physician. Any treatment or medication must be prescribed by the physician. . . . By any standard, a nurse has a *prima facie* duty to follow instructions given by the treating physician.”).

85. 61 AM. JUR. 2d *Physicians, Surgeons, and Other Healers* § 267 (2010) (“A doctor is vicariously liable for the negligence of nonemployee personnel only when those personnel are delegated to them by the doctor as his agent.”).

86. Baker, *supra* note 25, at 346.

87. Carolyn Buppert, *Implications for Collaborating Physicians*, 3 J. NURSE PRAC. 306, 307 (2007).

88. RESTATEMENT (THIRD) OF AGENCY § 7.07 cmt. f(2006).

basis from which to infer a right to control.⁸⁹ Georgia, for example, defines the “nurse protocol agreement” required under its laws as “a written document mutually agreed upon and signed . . . by which document the physician delegates to that advanced practice registered nurse the authority to perform certain medical acts . . . which acts may include . . . the ordering of drugs, medical devices, medical treatments, [and] diagnostic studies”⁹⁰ Use of the very term “delegate” implies that the physician is the ultimate gatekeeper of what is included in the agreement.⁹¹ However, power over *what* care an NP may provide, although implying some level of control, does not necessarily imply control over the *manner* in which that care is provided.⁹² This is a potentially significant distinction.⁹³

In one recent case, a court in North Carolina declined to find that a hospital had the right to control an anesthesiologist since the hospital did not possess the “‘right to control the manner or method’ of the anesthesiology work performed”⁹⁴ However, this case is distinguishable from the NP-physician context. In *Diggs v. Novant Health, Inc.*, by the terms of the agreement between the hospital and the anesthesiologist, the hospital only reserved the right to ensure physician compliance with hospital policies and the right to remove the physician from service.⁹⁵ With NP protocol agreements, however, the control exercised is much more directly related to the nature of care provided by

89. See Buppert, *supra* note 87, at 308 (“[S]tate law requirements for collaboration generally state or imply some level of control or oversight.”).

90. GA. CODE ANN. § 43-34-25(a)(10) (2009); see also *supra* note 64.

91. This inference is bolstered by Safriet who argues that under these statutory schemes, the state has delegated to the physician essentially total control over determining the ability of the NP to practice. Safriet, *supra* note 63, at 452.

92. The fact that courts have generally been careful to specifically emphasize the central importance of controlling the manner of work is telling because presumably all employers have the right to control what tasks an employee does in the course of their employment. See, e.g., *Keitz v. Nat’l Paving & Contracting Co.*, 134 A.2d 296, 301 (Md. 1957) (“The decisive test in determining whether the relation of master and servant exists is whether the employer has the *right to control and direct the servant in the performance of his work and in the manner in which the work is to be done.*”) (emphasis in original).

93. The comments provided to the *Restatement* offer the following passage that, at least arguably, well-suits the case of NP supervision and collaboration:

In some employment relationships, an employer’s right of control may be attenuated. For example, senior corporate officers, like captains of ships, may exercise great discretion in operating the enterprises entrusted to them, just as skilled professionals exercise discretion in performing their work. Nonetheless, all employers retain a right of control, however infrequently exercised.

RESTATEMENT (THIRD) OF AGENCY § 7.07 cmt. f (2006).

94. *Diggs v. Novant Health, Inc.*, 628 S.E.2d 851, 858 (N.C. Ct. App. 2006) (citation omitted).

95. *Id.*

the NP. Written protocols related to NP prescriptive authority are highly specific; one statute even sets forth the specific drugs which may be prescribed, the circumstances under which they may be prescribed, and the number of refills that may be ordered.⁹⁶ Therefore the specificity of the protocols, as well as the fact that they bear directly on the nature of care provided by NPs, support the notion that a “right to control” arises between the physician and the NP because both are suggestive of a greater degree of control held by the physician.⁹⁷

Many other relevant factors suggested by the *Restatement*, however, cut against a finding that supervising or collaborating physicians have the requisite “right to control” NPs—namely, that NPs increasingly use separate practice settings and bill distinctly for their services.⁹⁸ As NPs increasingly shift to providing care in settings other than doctor’s offices, physicians are usually not providing the supplies and instrumentalities used by the NP in providing care, and NPs are billing separately for their services.⁹⁹ Finally, for both practical and liability purposes, it seems unlikely that either the NP or the physician would characterize the relationship arising out of a collaboration agreement as master-servant.¹⁰⁰

One of the original motivations for using *respondeat superior* to reach physicians in the event of nursing malpractice was to ensure adequate compensation to the victim.¹⁰¹ In light of this motivation, the narrow circumstances under which supervision and collaboration arrangements may actually give rise to physician liability undermines the efficacy of

96. See, e.g., GA. COMP. R. & REGS. § 360-32-.02(5)(a)-(c) (2009).

97. See RESTATEMENT (THIRD) OF AGENCY (2006) § 7.07(3)(a).

98. See RESTATEMENT (THIRD) OF AGENCY § 7.07 cmt. f (2006) (stating that a factor to be considered is “whether the agent or the principal supplies the tools and other instrumentalities required for the work and the place in which to perform it”); see also Baker, *supra* note 23, at 328–29 (discussing the fact that the federal government has authorized “direct third party payment for NP services” and suggesting that private third party payors are likely to follow suit); *supra* note 50 (noting states that currently have no collaboration or supervision requirements for NPs).

99. RESTATEMENT (THIRD) OF AGENCY § 7.07 (2006). The NP-collaborating physician relationship is somewhat unique compared to other traditional master-servant relationships where the relevant payment would be from the master to the servant. With this relationship, the NP (the potential servant) is compensating the physician (potential master) for their involvement instead of the other way around. Because physicians who are parties to these agreements are typically paid one-time consulting fees, this would also seem to cut against finding a right to control.

100. Although the third *Restatement* states that the label the parties give to a relationship is not dispositive as to whether an agency relationship exists, the second *Restatement* recognizing the parties’ characterization of the agreement as a factor in determining whether an agency relationship arose. RESTATEMENT (THIRD) OF AGENCY § 1.02; RESTATEMENT (SECOND) OF AGENCY § 220(2)(i) (1958).

101. See 27 AM. JUR. 2D *Employment Relationship* § 374 (2004) (stating that one purpose of *respondeat superior* liability is “to give greater assurance of compensation for the victim”); see also W. PAGE KEETON, DAN B. DOBBS, ROBERT E. KEETON & DAVID G. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS 6 (W. Page Keeton ed., 5th ed. 1994).

these requirements in furthering that end.¹⁰² Furthermore, to the extent supervisory and collaborative relationships currently give rise to a duty owed by the physician to the patient, these laws facilitate inefficient liability shifting by imposing liability on less culpable actors—here, physicians who were likely not directly involved in providing care to the particular patient.¹⁰³ When supervising or collaborative physicians bear a portion of the malpractice liability arising from NP practice, the deterrent effect of malpractice liability on NPs is weakened.¹⁰⁴ One potential

102. Buppert suggests that if the physician merely “sponsors or supervises a mid-level provider,” they face only “minor liability exposure” for the acts of the supervised provider. Buppert, *supra* note 87, at 306. If this is the case, then continuing to require this relationship is at best only playing a minimal role in assuring sufficient compensation. Compare *Morvillo v. Shenandoah Mem’l Hosp.*, No. 5:07CV00046, 2008 WL 4179264, at *6, *8 (W.D. Va. Sept. 10, 2008) (holding 18 Va. Admin. Code § 90-30-120, requiring CRNAs to work under the direction and supervision of a licensed physician, did not, by itself, create a relationship between the supervising anesthesiologist and the patient giving rise to a duty of care; the case instead turned on a determination of the applicability of *respondeat superior* between the CRNA and the anesthesiologist and thus, whether that relationship was that of master-servant), with *Ware v. Timmons*, 954 So. 2d 545, 554 (Ala. 2006) (hospital procedure manual and state statute requiring that CRNAs be under the direction of a physician when providing anesthesia care was sufficient to establish a reserved right of control, but this factor alone was insufficient to support vicarious liability absent evidence of a right of selection since CRNA and supervising anesthesiologist were co-employees). Texas has attempted to legislate clarity into this issue. See TEX. OCC. CODE ANN. § 157.001(b) (Vernon 2004) (“The delegating physician remains responsible for the medical acts of the person performing the delegated medical acts.”); TEX. OCC. CODE ANN. § 157.060 (Vernon 2004) (“Unless the physician has reason to believe the physician assistant or advanced practice nurse lacked the competency to perform the act, a physician is not liable for an act of a physician assistant or advanced practice nurse solely because the physician signed a standing medical order . . .”).

103. Alan O. Sykes, *The Boundaries of Vicarious Liability: An Economic Analysis of the Scope of Employment Rule and Related Legal Doctrines*, 101 HARV. L. REV. 563, 569 (1988) (“The ultimate efficiency or inefficiency of vicarious liability . . . depends, however, on its effect upon employees’ incentives to avoid wrongful conduct.”).

[I]n short, doing all the things that constitute modern living—there must of necessity be losses, or injuries of many kinds sustained as a result of the activities of others. The purpose of the law of torts is to adjust these losses, and to afford compensation for injuries sustained by one person as the result of the conduct of another.

KEETON ET AL., *supra* note 101, at 6, quoting Wright, *Introduction to the Law of Torts*, 8 CAMBRIDGE L.J. 238, 238 (1944). “So far as there is one central idea, it would seem that it is that liability must be based upon conduct which is socially unreasonable.” KEETON ET AL., *supra* note 101, at 6. See also, e.g., Glanville Williams, *The Aims of the Law of Tort*, in CURRENT LEGAL PROBLEMS 137, 138 (George W. Keeton & Georg Schwarzenberger eds., 1951), as summarized in MARK LUNNEY & KEN OLIPHANT, TORT LAW: TEXT AND MATERIALS 18–19 (3d ed. 2008) (proposing that there are four bases for actions in tort: appeasement, justice, deterrence, and compensation); Richard A. Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29, 33 (1972) (“[T]he dominant function of the fault system is to generate rules of liability that if followed will bring about, at least approximately, the efficient—the cost-justified—level of accidents and safety.”).

104. See, e.g., Safriet, *supra* note 63, at 478–86; Mary Beck, *Improving America’s Health Care: Authorizing Independent Prescriptive Privileges for Advanced Practice Nurses*, 29 U.S.F. L. REV. 951, 965 (1995) (“Health policy is disadvantaged when liability is shifted upon an MD, because the

counterargument to this is that physicians would respond by only working with certain NPs, thereby making up for this incentive deficit by encouraging NPs to practice at the requisite caliber in order to maintain a relationship with their supervisory or collaborative physician. There is a monitoring problem, however, because the physician has only limited information about how an NP practices on a day-to-day basis.¹⁰⁵ The physician is not involved in every case, and not every case of malpractice by an NP will be discovered and litigated.¹⁰⁶ Because the physician is unlikely to have the information necessary to accurately assess the risk of an NP's malpractice, this feedback mechanism is unlikely to create incentives for quality to the same degree as imposing direct and sole malpractice liability on NPs for the care they render.¹⁰⁷

IV. PROPOSAL

Physician supervision and collaboration requirements with respect to NPs should be eliminated. Proposals to increase practice independence for NPs are not new,¹⁰⁸ and full statutory independence is merely the final step in the evolution of these proposals to keep pace with the development of the NP profession. There are at least three primary issues arising from physician supervision and collaboration requirements that justify their elimination. First, the NP profession has developed to such an extent that these requirements are no longer needed to achieve their original purpose,

deterrence goal of malpractice is hindered where liability is shifted away from the wrongdoer and the incentive to avoid malpractice removed.”)

105. This is a problem analogous to the foundational example in the law and economics literature addressing what is commonly known as the “principal-agent problem.” See Joseph E. Stiglitz, *Principal and Agent*, THE NEW PALGRAVE DICTIONARY OF ECONOMICS ONLINE (Steven N. Durlauf & Lawrence E. Blume eds., 2008), http://www.dictionarofeconomics.com/article?id=pde2008_P000183&q=principal%20agent&topicid=&result_number=1. “A principal-agent problem arises when there is imperfect information, either concerning what action the agent has undertaken or should undertake. In many situations, the actions of an individual are not easily observable.” *Id.*

106. Studies have shown that up to 98,000 patients die each year as a result of avoidable medical mistakes and that only approximately “one in eight instances of medical malpractice result[s] in a claim.” Leo Boyle, *The Truth About Medical Malpractice*, TRIAL, Apr. 1, 2002, available at <http://www.thefreelibrary.com/The+truth+about+medical+malpractice-a086391224>.

107. This is analogous to the principal-agent problem in that the system should provide NPs with the incentive to exercise that level of care which will maximize both their utility and the utility of their supervising/collaborating physicians (i.e., minimizing the risk and scale of their malpractice liability). See Stiglitz, *supra* note 104 (stating that in the principal-agent problem, the goal is to find the contract “which maximizes the expected utility of the principal, given that (a) the agent will undertake the action(s) which maximizes his expected utility, given the . . . scheme . . .”).

108. See generally Safriet, *supra* note 63 (advocating for independent prescriptive authority); Hadley, *supra* note 2 (advocating for independent prescriptive authority); *supra* note 55 (listing states which do not require physician involvement in NP practice).

which was to ensure the provision of quality care by NPs.¹⁰⁹ The intraprofessional and administrative quality safeguard mechanisms already in place for NPs are sufficient to achieve the same levels of quality and would simplify the regulatory scheme.¹¹⁰ Second, mandatory physician supervision and collaboration schemes leave the question of liability of the supervising physician with regards to instances of mistakes and malpractice largely unanswered.¹¹¹ The unsettled nature of this issue muddles malpractice issues and distorts NPs' incentives to deliver quality care.¹¹² Finally, physician supervision and collaboration requirements leave the NP profession economically vulnerable to physicians—who have an economic conflict of interest since NPs are, at least partial, competitors.¹¹³ This final point carries broad implications for the potential success of innovative delivery structures that depend on mid-level practitioners, such as NPs, to achieve their goals of lower cost and increased access.¹¹⁴ While independent practice authority is not a new idea, the growing demands on the health care system and creative solutions—such as RHCs, which could be stifled—make this third point particularly timely.¹¹⁵

109. See *supra* notes 14 (quality assurance purpose of licensure laws), 36 (certification requirements), 39 (increasing specialization of NPs), 43 (accreditation), 98 (third party payor recognition), *infra* notes 127 (comparison of training requirements to MDs), 146 (carry independent malpractice insurance) and accompanying text.

110. See *supra* notes 43, 45–46, 49.

111. See *supra* notes 86–100 and accompanying text.

112. See *supra* notes 102–04.

113. See *supra* notes 41–42, *infra* note 142; see also Safriet, *supra* note 63, at 449 (asserting that competitive bias can arise “when one profession is empowered to define the practice boundaries of other related professions, and the latter provide services still offered by the former”).

114. See Sage, *supra* note 7, at 511, 514; Convenient Care Association Fact Sheet, *supra* note 9, at 1 (attributing the ability of RHCs to provide less expensive care to the utilization of “certified physician assistants or nurse practitioners rather than physicians . . .”).

115. See *supra* notes 5–9. Also making this a particularly apt time to embrace an expanded role for NPs is the fact that President Obama has made health care reform a primary priority of his administration. In his discussions on the topic, President Obama has repeatedly discussed the need for reform as a means of “bending the cost curve” down to address the ballooning costs of health care. Barack Obama, President of the United States, Remarks in Town Hall Meeting on Health Care at Southwest High School, Green Bay, Wisconsin (June 11, 2009), available at http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-in-Town-Hall-Meeting-on-Health-Care-in-Green-Bay-Wisconsin/ (“If we can bend the curve, the cost-curve down so that health care inflation is no more than ordinary inflation . . . then we’re going to be okay.”); William Safire, *Bending the Curve*, N.Y. TIMES, Sept. 14, 2009, § 6 (Magazine), at 14 (reporting that President Obama remarked that “it’s important for us to bend the cost curve, separate and apart from coverage issues, just because the system we have right now is unsustainable and hugely inefficient and uncompetitive”) (emphasis in original).

A. Modern NP Profession

Statutory independence for NPs would more accurately reflect the current status of the NP profession by recognizing the development of NPs into professionals trained and qualified to exercise independent clinical judgment.¹¹⁶ Since the profession was created in the 1970s, NPs have increasingly moved from the more dependent functioning characteristic of the traditional nursing model towards “comprehensive assessment and independent decision making.”¹¹⁷ Alongside this expansion of the scope of practice of NPs, the professional and statutory regulatory context in which NPs function has likewise evolved to accommodate the expanded role of NPs.¹¹⁸ The transition to eligibility of NPs for direct-third-party payment is perhaps among the most significant indicators of the increasing acknowledgement of NPs as independent practitioners.¹¹⁹ In light of the changed reality of modern NP practice, physician supervision and collaboration requirements are no longer necessary to ensure that NPs provide a high quality of care to their patients.

To begin with, there is no evidence that NPs are generally inclined to provide care at lower levels of quality than physicians when performing acts and providing care within the general scope of their practice.¹²⁰ According to a study commissioned by Congress and conducted by the Office of Technology Assessment, studies comparing the care given by physicians and NPs “find that the quality of care provided by NPs functioning within their areas of training and expertise tends to be as good or better than care provided by physicians.”¹²¹ More recent studies have confirmed this, concluding that patient outcomes do not differ between care provided by NPs and care provided by physicians.¹²² The evidence further shows higher patient retention rates and patient satisfaction with the care provided at nurse-managed health centers compared to like providers.¹²³ These studies, combined with the fact that supervision and

116. See Baker, *supra* note 25, at 341

117. *Id.*; see also Aiken & Sage, *supra* note 19, at 201.

118. See Hadley, *supra* note 2, at 248–50.

119. Baker, *supra* note 25, at 328–29.

120. In fact, the evidence seems to support the parity in terms of quality. See Sage, *supra* note 7, at 512.

121. Ritter & Hansen-Turton, *supra* note 23, at 22 (quoting U.S. CONGRESS, OFFICE OF TECH. ASSESSMENT, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS 19 (1986)).

122. Mary O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 JAMA 59, 66 (2000).

123. Tine Hansen-Turton, *The Nurse-Managed Health Center Safety Net: A Policy Solution to*

collaboration regimes have, at best, an indirect impact on the quality of care provided to individual NP patients,¹²⁴ are strong evidence that NPs practicing independently are capable of providing care at high levels of quality.¹²⁵

Furthermore, the remaining safeguards and disciplinary mechanisms under an independent practice regime are sufficient to oversee the NP profession and address quality-of-care issues.¹²⁶ Even absent physician supervision and collaboration, NPs face largely the same rigorous regulatory and administrative practice environment as physicians and other nonmedical professionals.¹²⁷ Most states require NPs to meet education and training requirements, pass national certification examinations, and be approved under the state licensure process.¹²⁸ NPs are likewise subject to disciplinary measures by the state board of licensure in the event they demonstrate a failure to meet the standards of the profession in the provision of patient care.¹²⁹ Disciplinary mechanisms by licensing boards

Reducing Health Disparities, 40 NURSING CLINICS N. AM. 729, 734–35 (2005). Although it is likely that much of the evidence examined in these studies were of NPs providing care under some sort of supervision or collaboration regime, these results are still a compelling indicator of the ability of NPs to provide high levels of care independently since even under such a regime the NP would still have been functioning largely independently. Therefore, the impact of the limited role of a supervising or collaborating physician on quality on a day-to-day basis would be indirect at best. *See also supra* notes 59–62 and accompanying text. Where on-site supervision is required, it usually covers only a relatively small portion of the total practice time of the NP. *See supra* note 59.

124. This impact is indirect in the sense that protocols are usually relatively general in nature, and it is still the NP who assesses the patient and provides the care.

125. *See supra* note 125.

126. *See supra* notes 43, 45–46, 49.

127. The regulatory structure for physicians is largely analogous to that which governs NPs. “To be licensed, physicians must graduate from an accredited medical school, successfully pass required licensing examinations, and complete one to seven years of graduate medical education in the form of an internship and residency.” Yuri N. Walker, *Protecting the Public: The Impact of the Americans with Disabilities Act on Licensure Considerations Involving Mentally Impaired Medical and Legal Professionals*, 25 J. LEGAL MED. 441, 444 (2004) (footnote omitted). Additionally, “[e]very state . . . has a medical licensure board responsible for controlling entry into the medical profession by means of licensure and disciplining physicians who are incompetent or engage in unprofessional conduct.” *Id.* Likewise, NPs are generally required to attend an accredited masters-level program, pass licensing examinations, and are subject to examination and discipline by state nursing boards. *See supra* Part II.A; *see also* American Academy of Nurse Practitioners, Qualification of Candidates, <https://www.aanpcertification.org/ptistore/control/certs/qualifications> (last visited May 10, 2010) (requiring graduation from an approved masters, post-masters, or doctoral level nurse practitioner program to be eligible for certification).

128. *See supra* notes 35–36, 43–44.

129. MODEL NURSING PRACTICE ACT art. XI, § 1 (Nat’l Council of State Bds. of Nursing 2009) (authorizing the board of nursing to refuse to issue or renew, limit or restrict, suspend, or revoke a license, impose civil penalties of up to \$10,000 per violation and impose fines). Among the grounds for discipline cited in the Model Act are: “failure to demonstrate the qualifications or satisfy the requirements for licensure,” engaging in unethical conduct including “demonstrating a willful or careless disregard for the health or safety of a client,” and engaging in unsafe or unprofessional

are a particularly valuable quality safeguard as the disciplinary authority of these boards is often not conditioned on a demonstration that actual harm was inflicted due to the lack of care of the professional.¹³⁰ Some states have also imposed rules mandating that certain entities report instances related to NP professional conduct and capacity.¹³¹

Additionally, nongovernmental entities act as a check on the quality of NP care. In order for practicing NPs to retain certification, the American Academy of Nurse Practitioners requires members to re-certify every five years—a process which includes sitting for an examination, as well as completing a minimum of 1000 hours of clinical practice and seventy-five hours of continuing education in their area of specialization.¹³² Health care entities utilizing NPs also act as a safeguard against substandard NP practice.¹³³ These entities will try to hire only well-qualified NPs to provide care and will generally take reasonable steps to monitor the quality of care offered by their providers.¹³⁴ This is motivated both out of an economic concern to ensure the quality of the product they offer to patients, as well as a desire to avoid potential corporate liability in the event an NP provides negligent care while practicing at their facility.¹³⁵

practice including the failure “to practice nursing with reasonable skill and safety” or any “departure from or failure to conform to nursing standards.” *Id.* § 2.

130. See, e.g., Lisa E. Bartra, *Reconsidering the Regulation of Health Professionals in Kansas*, 5 KAN. J.L. & PUB. POL’Y 155, 161 (1996) (noting licensure provisions that also provide for the discipline of unqualified providers who cause a risk of harm). Furthermore, nowhere in the Model Nursing Practice Act’s articulation of the grounds for board discipline is actual injury to a patient required. See MODEL NURSING PRACTICE ACT, *supra*. In fact, with regard to unethical conduct and “[c]onduct or any nursing practice that may create unnecessary danger to a client’s life, health or safety,” the Model Nursing Practice Act specifically states that “[a]ctual injury need not be established.” *Id.* § 2(e), (g)(5).

131. See, e.g., 225 ILL. COMP. STAT. ANN. 65/65-65 (West Supp. 2009) (requiring health care institutions, professional associations, professional liability insurers, state’s attorneys, and state agencies to make such reports to the Board of Nursing).

132. American Academy of Nurse Practitioners, Qualifications: Recertification for Adult and Family Nurse Practitioners, <http://www.aanpcertification.org/ptistore/control/recert/qualifications> (last visited May 10, 2010).

133. See *infra* notes 151–58 and accompanying text for a discussion of the issue of corporate liability.

134. See Hadley, *supra* note 2, at 296 (discussing institutional safeguards “such as hospital admitting privileges and internal committees monitoring the quality of care” as an additional safeguard against incompetent professionals).

135. Presumably these internal checks could take a form analogous to those already used by hospitals and other health care entities. *Id.*; see also *supra* notes 151–58.

B. Clarifying Malpractice Liability Rules and Incentives for Quality

Under my proposed scheme of full statutory practice independence for NPs, a practicing NP would generally bear the full liability for instances of malpractice arising from care provided by that NP. In addition to sidestepping difficult right-to-control issues, eliminating this potential for liability shifting furthers efficiency by insuring that NPs face optimal incentives to provide high-quality care to their patients.¹³⁶

One counterargument is that independent NP practice could lead to instances where patients are injured when they fall through the cracks between the standard of care applicable to NPs and that which applies to physicians.¹³⁷ Currently, NPs in most states are required to exercise that level of care which a reasonable NP would exercise under the circumstances while a physician must rise to the standard of a reasonable physician.¹³⁸ The argument is that there will inevitably be instances where a patient has an issue or ailment that a physician would be expected to identify and address in order to fulfill the duty of care they owe their patients, while a failure to do so by an NP would not violate the NP standard of care.¹³⁹ Thus, the patient in such a case would have a malpractice claim if the provider was a physician, but not if the provider was an NP. One potential answer to this criticism is the Doctrine of Delegated Acts, which assumes “that acts characterized as medical retain that characterization for all time,” regardless of whether that act is subsequently delegated to mid-level practitioners.¹⁴⁰ Application of this

136. See *supra* notes 102–04.

137. See Phyllis Coleman & Ronald A. Shellow, *Extending Physician’s Standard of Care to Non-Physician Prescribers: The Rx for Protecting Patients*, 35 IDAHO L. REV. 37, 79 (1998) (“[D]ifferent standards of care might well be ‘disastrous’ for the injured plaintiff who was doubly unlucky: first, he was the victim of malpractice; and second, the person who injured him was a non-physician provider with a lower standard of care.”). But see Beck, *supra* note 104, at 965 (“The standard of care by which a court should measure advanced nursing practice should be that degree of skill and learning commonly exercised by a prudent and reasonable member of the APN profession.”).

138. *Dooley v. Everett*, 805 S.W.2d 380, 385 (Tenn. Ct. App. 1990) (“[O]ne who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities.”) (citation omitted); *Fein v. Permanente Med. Group*, 695 P.2d 665, 674 (Cal. 1985) (“examination” and “diagnosis” are not, as a matter of law, functions reserved exclusively for physicians, and therefore the trial court erred in holding NP to physicians’ standard of care); see also, e.g., N.C. GEN. STAT. § 90-21.12 (2008) (must consider whether care was “in accordance with the standards of practice among members of the same health care profession with similar training and experience”); IDAHO CODE ANN. § 6-1012 (2004) (health care providers are to be judged against “similarly trained and qualified providers of the same class . . . taking into account his or her training, experience, and fields of medical specialization . . .”).

139. Coleman & Shellow, *supra* note 137, at 79.

140. Baker, *supra* note 25, at 342. The notion that some tasks are inherently medical has been

rule would essentially result in NPs being held to the physician duty of care in a great number of the professional tasks they perform, since physician practice arguably encompasses all that NPs are capable of performing.¹⁴¹ This would mean that theoretically no patients would fall through the cracks.

Even if the different duties of care are applied to NPs, that fact alone is insufficient to justify dependent NP practice. It is not necessary to conclude that NPs and physicians are entirely equivalent in terms of education, training, qualifications, or clinical abilities in order to justify independent practice; only that NPs are capable of providing interchangeable levels of care within their permitted scope of practice.¹⁴² Therefore, any concerns about patients falling through the cracks are more appropriately addressed in terms of NP scope of practice through Nurse Practice Acts and the duty of referral, and not through dependent practice. Finally, it is important to note that in many instances where patients visit NPs, they are not simply choosing between seeking care from a physician versus an NP; due to either cost or convenience considerations, or a combination of the two, many patients may be choosing between NP care or not seeking care at all.¹⁴³

Another possible criticism is that dependent practice is necessary to ensure that patients injured as a result of malpractice will be adequately compensated. This argument is largely predicated on the fact that traditionally, NPs have obtained malpractice insurance via the malpractice

criticized, however. *See Fein*, 695 P.2d at 674 (rejecting jury instruction stating that NP's conduct in performing tasks delegated by supervising physician must be measured against standard of care of physician).

141. However, many courts have implicitly rejected the argument that NPs and physicians should be held to the same duty of care. *See Baker*, *supra* note 25, at 341 (discussing the overlap between tasks performed by NPs and those performed by physicians). *See also, e.g., Simonson v. Keppard*, 225 S.W.3d 868, 872 (Tex. Ct. App. 2007) (inappropriate to use neurosurgeon to provide expert testimony as to the standard of care for NPs because different standards of care apply to a diagnosis performed by NP versus a diagnosis by a physician); *Land v. Barnes*, No. M2008-00191-COA-R3-CV, 2008 WL 4254155, at *6 (Tenn. Ct. App. Sept. 10, 2008) (excluding testimony of both a physician and a physician assistant regarding applicable standard of care for nurse practitioners on grounds that both witnesses failed to establish that they were sufficiently familiar with the standard of care for NPs).

142. *See Baker*, *supra* note 25, at 341 (discussing the "interprofessional intersection" between NPs and physicians, concluding that in areas where "[t]he expanded role of the NP is coextensive . . . with the practice of medicine. . . . The medical services rendered . . . are essentially the same. The difference is the model of care delivery").

143. *See Sage*, *supra* note 7, at 514-15 (discussing fact that many RHC patrons are uninsured and arguing that because of the lower cost and enhanced convenience factors, the cost-benefit balancing performed by patients contemplating whether or not to seek certain basic forms of care is more likely to favor seeking care with RHCs than when physicians are the only potential option).

insurance policies of the physicians with whom they work.¹⁴⁴ Thus, critics might argue that dependent practice is an important safeguard to make certain that NPs are adequately insured, thereby satisfying the compensation goal of malpractice tort liability.¹⁴⁵ This concern is not compelling, however, in light of the fact that independent NP malpractice policies are currently available and are likely to become more standard for the profession with the implementation of independent practice.¹⁴⁶ Furthermore, as discussed previously, this issue is insufficient to justify dependent practice due to the uncertainty surrounding the issue of when a supervising or collaborating physician may be held liable for the NP's actions.¹⁴⁷ At least one expert in the field, Carolyn Buppert, has concluded that a physician who does not employ, but supervises or collaborates with an NP faces only "minor liability exposure."¹⁴⁸ Therefore, at best, dependent practice offers a very narrow set of circumstances in which this additional pool of money would be available to compensate a malpractice victim. Concerns regarding the sufficiency of compensation for malpractice victims under an independent practice scheme are further alleviated by the continuing presence of hospitals, RHC companies, and other entities utilizing NPs. This effect is two-fold. First, when entities such as these engage NPs in the delivery of care, they ensure that those NPs are adequately insured—either by providing the insurance themselves or by requiring that the NP carry a certain level of insurance as a condition of providing care through the entity.¹⁴⁹ Second, hospitals and other health

144. Before independent malpractice policies for NPs became available, NPs practicing in a physician practice generally relied on the insurance policy of the physician through the use of what is known as a "rider," which is merely an attachment or added provision to a policy that, in this context, modifies the policy so as to include the NP. BLACK'S LAW DICTIONARY 1347 (8th ed. 2004) ("An attachment to some document, such as a legislative bill or an insurance policy, that amends or supplements the document.").

145. See *supra* note 101 and accompanying text.

146. Baker, *supra* note 25, at 344, 336 (asserting that "[t]oday, NPs can and do carry their own malpractice liability insurance" and that "[e]very professional has an obligation to carry sufficient malpractice coverage to ensure that a patient injured by malpractice will be justly compensated"). A brief internet search turned up several companies that offer NP-specific malpractice policies, including companies such as Nurses Service Organization, Proliability/Marsh Inc., and CM&F Group Inc., to name a few.

147. See *supra* Part III.

148. See Buppert, *supra* note 87, at 306.

149. The rationale for these measures would be largely the same as those motivating institutional competency safeguards, except that maintaining adequate insurance does not directly help to avoid malpractice liability. See Hadley, *supra* note 2, at 296. Presumably such institutional safeguards are also, at least to some extent, intended to protect the reputation of the health care entity. There are three potential reasons why an entity employing NPs would do this: (1) For the business reason that patients are less likely to visit a clinic which is under-insured; (2) there are state requirements mandating some

care entities (such as RHCs) which choose to employ or otherwise utilize NPs may be liable under a theory of corporate negligence.¹⁵⁰ Corporate liability is premised on the notion that entities such as hospitals owe certain duties directly to the patients who seek care from their institutions.¹⁵¹ Those duties include a duty to oversee those who provide care through the institution and a duty to develop adequate rules and enforcement mechanisms to ensure high-quality care.¹⁵² Thus, under a theory of corporate negligence, hospitals, and other health care entities may be held liable even if *respondeat superior* does not apply.¹⁵³ Imposition of this liability is justified, proponents argue, because hospitals are increasingly presenting themselves to the public as the source of health care, instead of the particular professionals who actually provide the care offered by the institutions.¹⁵⁴ Furthermore, hospitals are arguably in the best position to monitor the quality of their staff and the quality of care.¹⁵⁵ Corporate liability would be limited to instances of negligent hiring and monitoring, on the part of the corporation or institution, of the quality and qualifications of NPs providing care on their behalf.¹⁵⁶ The limited scope of corporate liability is appropriate in order to avoid the same

minimum level of insurance; (3) concerned about liability exposure of the larger entity in the event of malpractice by the NP.

150. Corporate negligence has been described as “a doctrine under which the hospital is liable if it fails to uphold the proper standard of care owed the patient” that “creates a nondelegable duty which the hospital owes directly to a patient.” *Thompson v. Nason Hosp.*, 591 A.2d 703, 707 (Pa. 1991). Thus, under corporate negligence, there would be no need to affirmatively establish that the NP was negligent in any way. *Id.* This is in sharp contrast to a claim based on a theory of *respondeat superior*, which requires such a finding as a threshold matter, since it is a form of vicarious liability. See RESTATEMENT (THIRD) OF AGENCY § 2.04 (2006).

151. David H. Rutchik, Note, *The Emerging Trend of Corporate Liability: Courts’ Uneven Treatment of Hospital Standards Leaves Hospitals Uncertain and Exposed*, 47 VAND. L. REV. 535, 536 (1994).

152. *Thompson*, 591 A.2d at 707. The case suggested that a hospital’s duties could be broken into four categories:

- (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment;
- (2) a duty to select and retain only competent physicians;
- (3) a duty to oversee all persons who practice medicine within its walls as to patient care; and
- (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients.

Id. (citations omitted). Presumably, this argument could be expanded to all categories of health care providers practicing at the hospital.

153. Rutchik, *supra* note 151, at 536.

154. See *id.* at 548 (explaining the corporate liability trend as growing from general public perception and reliance on hospitals as the healthcare provider instead of the particular physicians, nurses and other health care professionals).

155. *Id.* at 549.

156. This scheme would therefore be analogous to cases where hospitals are held liable for negligently granting privileges to unqualified physicians and surgeons. See, e.g., *Strubhart v. Perry Mem’l Hosp. Trust Auth.*, 903 P.2d 263 (Okla. 1995).

inefficiencies identified previously with regard to liability shifting to supervising physicians under a theory of *respondeat superior*.¹⁵⁷ Thus, corporate negligence provides another layer of safeguards for quality NP practice, by encouraging hospitals to engage in careful hiring and administration. It is important to note, however, that this theory has not been universally accepted by courts.¹⁵⁸

Statutory independent practice for NPs has the potential to rationalize incentives for quality NP care without sacrificing malpractice victim compensation. Independent practice would simplify malpractice liability related to NP practice, thereby making the deterrent effect of malpractice liability more vigorous.¹⁵⁹ At the same time, independent NP malpractice insurance, combined with the possibility of a distinct basis of liability for the entities contracting with and employing NPs, moots concerns regarding the sufficiency of compensation to malpractice victims.

C. Statutory Independence Achieves Important Public Policy Objectives

Independent NP practice is an essential element for granting NPs the professional recognition they have earned and furthering the goal of rationalizing the manner in which health care is delivered.¹⁶⁰ In a system of fully independent practice by NPs, NPs would be encouraged to utilize the full range of their qualifications by exercising their independent clinical judgment, allowing greater flexibility to meet patient needs. Physician supervision and collaboration requirements have a “corrosive effect on . . . [NPs’] sense of professionalism” by requiring NPs to constantly seek physician approval of the manner in which they provide care.¹⁶¹ Elimination of these rules would also reduce the possibility that

157. See *supra* notes 102–07 and accompanying text.

158. See, e.g., *Gafner v. Down E. Cmty. Hosp.*, 735 A.2d 969 (Me. 1999) (rejecting corporate liability as a new cause of action which would have provided for direct liability against hospitals and medical facilities); *Barkes v. River Park Hosp., Inc.*, No. M2006-01214-COA-R3-CV, 2008 WL 5423981 (Tenn. Ct. App. Dec. 29, 2008) (rejecting corporate negligence as a theory by which to impose liability on hospital due to breach of duty of care owed by the hospital directly to the patient). Additionally, for criticisms of the approach taken in *Thompson v. Nason*, 591 A.2d 703 (Pa. 1991), see Judith M. Kinney, Casenote, *Tort Law-Expansion of Hospital Liability Under the Doctrine of “Corporate Negligence,”* 65 TEMP. L. REV. 787 (1992); Mark E. Milsop, Comment, *Corporate Negligence: Defining the Duty Owed by Hospitals to Their Patients*, 30 DUQ. L. REV. 639 (1992). Both authors are particularly critical of the court’s failure to specify the content and nature of the duty owed by a hospital to its patients. *Id.* at 643; Kinney, *supra*, at 797.

159. See *supra* note 104 and accompanying text.

160. Safriet, *supra* note 63, at 452 (“At best, such schemes demean APNs’ professional role and ability, and further retard their full utilization in our health care system.”).

161. *Id.* at 451.

patients might misunderstand the physician's role and perceive the very existence of the requirements as evidence that NPs provide a lesser level of care or are in some way unqualified to provide care absent a physician's involvement.¹⁶² This is not to suggest that independent practice should signal to society that NPs are perfect substitutes for physician care in all circumstances, merely that there are circumstances in which an NP will be able to provide comparable levels of care as a physician.¹⁶³ Therefore, this clarification could also have the effect of broadening public understanding of the capabilities of NPs, which would aid individuals in making more informed choices when deciding whether to visit an NP or a physician.¹⁶⁴

Doing away with mandatory physician involvement also dispenses with the possibility that physicians will exercise "anti-competitive animus" towards NPs.¹⁶⁵ As demonstrated by the recent string of state legislative attempts to intensify supervision and collaboration requirements in response to the competitive success of RHCs, these rules provide a ready means by which physicians can control the financial prospects of potential competitors.¹⁶⁶ Safety- and quality-based criticisms of RHCs are suspicious, however, in light of the fact that the RHC concept relies on providing a very narrow range of care that is well within the confines of the scope of practice of NPs.¹⁶⁷ If the care provided by NPs in RHCs is among the most basic forms of care offered by NPs outside the RHC setting, there appears to be little, if any, justification for increased supervision and collaboration requirements simply because an increasing number of NPs are practicing in retail settings.¹⁶⁸

In addition to the drawbacks in terms of the professional status of NPs, leaving open this avenue for physicians to stifle the NP profession threatens the viability of innovative delivery reforms such as RHCs.¹⁶⁹ Any viable attempt at meaningful reform of the health care system will

162. This is analogous to an argument made in support of NP prescriptive authority. Beck, *supra* note 104, at 960 (arguing that "where the legal requirement for MD supervision exists . . . it suggests to the public that APNs lack knowledge to prescribe treatments for conditions they have diagnosed").

163. Hadley has suggested a reasonable and simple place to draw this line by using surgery as an example of the type of context in which "nurses are inherently complementary," but arguing that "in the provision of primary care and in outpatient settings, nurses can function as substitutes for physicians." Hadley, *supra* note 2, at 251.

164. See Kristin Madison, *Regulating Health Care Quality in an Information Age*, 40 U. C. DAVIS L. REV. 1577 (2007).

165. Safriet, *supra* note 63, at 452.

166. See *supra* notes 63, 70–71.

167. See Ohlhausen Letter, *supra* note 67, at 7.

168. *Id.*

169. See EXPRESS LANE, *supra* note 6, at 12; Ohlhausen Letter, *supra* note 67 and accompanying text.

need to accept that health care is a limited resource, particularly care provided by the most highly trained professionals such as physicians.¹⁷⁰ Thus, the key becomes allocating this resource in a rational and efficient manner.¹⁷¹ RHCs constitute a promising step towards more efficient delivery of care, which could simultaneously address both cost and access problems currently plaguing the health care industry.¹⁷² The idea underlying RHCs is that NPs are a vital ingredient to finding the “right” allocation of the “right types of professionals” to provide the optimal level of care to the overall population.¹⁷³ This idea is both promising and controversial for the same reason—it is a market-driven solution to a problem in the health care arena. Health care markets have long been viewed as unique and ill-suited to being left to normal market forces—a phenomenon which has been described as the “central paradox of contemporary health care markets.”¹⁷⁴

One of the most compelling arguments that can be made against market-based solutions to health care markets is that consumers generally lack the ability to adequately judge the quality of health care provided by a particular provider.¹⁷⁵ Instead, society largely relies on scope of practice and licensing statutes to delineate between health care professionals based on which profession is qualified to perform particular categories of care.¹⁷⁶ Many commentators have criticized the tradition of physician dominance since other health professions have developed their education and skill set to the point where they are, as a matter of standard practice, delegated many medical acts.¹⁷⁷ If other health care professionals are qualified and

170. See *supra* note 2.

171. Hammer, *supra* note 15, at 248 (“The critical organizational problem in health care is how to rationalize the utilization of care at the individual clinical setting in a manner that corresponds to collective needs and resource constraints.” (discussing NEIL FLIGSTEIN, *THE ARCHITECTURE OF MARKETS: AN ECONOMIC SOCIOLOGY OF TWENTY-FIRST-CENTURY CAPITALIST SOCIETIES* (2001))).

172. See Sage, *supra* note 3, at 1238–43.

173. See Sage, *supra* note 7, at 518 (“If the potential benefits of innovative care delivery models, including but not limited to retail clinics, are to be realized, the United States needs to produce enough of the right types of professionals to promote public health and provide acute and chronic services . . .”).

174. Hammer, *supra* note 15, at 259 (describing this paradox as the fact that markets are better equipped to achieve efficiency in rationing care but lack legitimacy on the individual clinical encounter level, while physicians enjoy legitimacy in individual clinical encounters, but are ill equipped to deal with issues of efficiency).

175. See, e.g., Madison, *supra* note 164, at 1584 (“Without some form of outside assistance, uninformed patients cannot choose their providers based on quality, pay their providers based on quality, or meaningfully contract based on quality.”).

176. See discussion *supra* Part II.A.

177. Hammer, *supra* note 15, at 237 (“From a historical perspective, the story of American health care is a story of physician dominance.”); *id.* at 258 (discussing two distinct mechanisms available to

proficient at performing certain categories of primary care, it would seem to follow that embracing such a division of labor would encourage a more efficient allocation of resources by leaving less complex health care services to less expensive, though qualified, professionals.¹⁷⁸ Quality must mean more than using the most highly trained professionals to provide all care—sensible policy must also consider cost and access.¹⁷⁹

Recent scientific research confirms the potential of RHCs to expand patient access to basic forms of care and to provide that care at a lower cost than alternative sources. One study comparing patient visits to RHCs with patient visits to primary care physicians and emergency departments concluded that “[r]etail clinics appear to be providing care to a patient population less likely to use PCPs [primary care physicians]”¹⁸⁰ The study found that only 67% of RHC visits were paid for by insurance, compared to 90% of physician visits.¹⁸¹ Because of the lower cost of care, RHCs are an attractive option for uninsured individuals who are bearing the full cost of any health care they seek.¹⁸² RHCs also contribute to cost savings on two levels. On the individual patient level, the average cost of an RHC visit is \$60, compared to \$283 for a physician visit.¹⁸³ RHCs also

rationalize costs: reliance on the market and reliance on a system of physician deference). For a discussion of implications of different standards of care, see *supra* notes 137–40 and accompanying text. Safriet has also been a staunch critic of relying on the traditional physician-centric delineation of the roles of all other health care practitioners, describing this structure as “a historical, but not inevitable, phenomenon.” Safriet, *supra* note 63, at 442. Safriet posits that this structure developed largely because physicians were simply the first health professionals to gain legislative recognition and when this occurred, “extremely broad” statutory definitions of physician practice were put in place. *Id.* at 441.

178. Sage, *supra* note 7, at 519.

179. The Institute of Medicine seems to agree, as they use a multi-dimensional approach to define “quality” which includes efficiency. See GOLDMAN, MCGLYNN & ALPERT, *supra* note 1, at 35.

180. Ateev Mehrotra et al., *Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients’ Visits*, 27 HEALTH AFF. 1272, 1281 (2008).

181. *Id.* at 1280.

182. Reports indicate that RHC companies see this as a major consumer base for these clinics, with many choosing to locate RHCs in areas which are perceived as having the greatest demand—those with significant uninsured or underinsured populations, and physician shortages. SCOTT, *supra* note 6, at 10. RHCs may also be an attractive option for individuals who are insured, but have a high-deductible policy which leaves the individual paying for these basic kinds of clinic visits.

183. See Convenient Care Association Fact Sheet, *supra* note 9. Granted, at least part of this discrepancy could be due to the fact that people tend to only go see a doctor or visit the emergency room for more serious, and therefore more expensive to address, issues. There is evidence, however, that there is more substance to the cost difference than this. A study by the Convenient Care Association found that “[f]orty percent or more of CCC patients report they would have gone to the emergency room, an urgent care center or forgone treatment altogether had there not been a CCC available” *Id.* This suggests that at least some RHC patients generally go to a health care entity of some kind for the conditions that brought them to an RHC—this may mean that a significant portion of patients seen by emergency rooms and physician practices were simple enough to be handled by an RHC. Buttressing this is a study that found that “[t]he cost of receiving treatment for strep throat at a

contribute to enormous aggregate savings across the health care industry as a whole by facilitating a system by which basic forms of care are provided by lower-cost providers, as opposed to a system where patients turn to far more expensive sources such as emergency departments.¹⁸⁴

One criticism of RHCs, which also arguably applies to all independent NP practice, is that these interfere with the maintenance of a “medical home” for each patient.¹⁸⁵ The “medical home” concept has been described as a “model of health care delivery based on an ongoing personal relationship with a physician” where the physician is responsible for providing all care or managing the care provided by other professionals.¹⁸⁶ The primary virtue of the medical home, according to proponents, is that it focuses on coordinating an individual’s care across the healthcare spectrum and ensures continuity of care by having the personal physician take “responsibility for appropriately arranging care with other qualified professionals.”¹⁸⁷ This criticism is not compelling for a number of reasons. First, no explanation has been offered as to why it would be more difficult for a personal physician to coordinate with an RHC than it would be to coordinate with any other form of health care

CCC is less than one third of what it costs at an emergency room.” *Id.* This is consistent with the significantly different labor and administrative costs faced by hospitals compared to those of an RHC. *See, e.g.,* EXPRESS LANE, *supra* note 6, at 11 (reporting that RHCs keep overhead low by operating in spaces with physical limitations, implying that such limitations are unique compared to most other practice settings); Sage, *supra* note 3, at 1238.

184. According to one study, 90.3% of RHC visits were for ten simple acute conditions and forms of preventive care. Mehrotra et al., *supra* note 180, at 1278. The study further found that those same ten clinical issues accounted for 18.1% of all primary care physician visits (87.76 million visits), and 12% of all visits to emergency rooms (13.53 million visits). *Id.* Thus, it is possible to get an extremely rough idea of the potential cost savings to the overall health care market through encouraging patients to seek care at RHCs instead of physician offices or emergency rooms by multiplying these numbers by the average visit costs for each of these care sources (*see supra* note 9) and then subtracting from that number the product of these combined visit numbers and the average cost of an RHC visit. Thus, the calculation would look something like this:

$$\begin{aligned} &(87.76 \text{ million physician visits} \times \$283 \text{ per visit}) + (13.53 \text{ million emergency room visits} \times \\ &\$445 \text{ per visit}) = \$30,856,930,000 \\ &(87.76 \text{ million} + 13.53 \text{ million}) \times \$60 \text{ per RHC visit} = \$6,077,400,000 \\ &\text{Difference} = \$24,779,530,000 \end{aligned}$$

185. Scott Harris, *Open for Business: Health Systems Explore Retail Clinics*, AAMC REP., Sept. 2008, <http://www.aamc.org/newsroom/reporter/sept08/clinics.htm> (“[S]ome say the retail clinic may clash with the patient-centered medical home . . .”).

186. Am. Med. Student Ass’n, Primary Care Interest Group, <http://www.amsa.org/AMSA/Homepage/About/Committees/PrimaryCare.aspx> (last visited Mar. 25, 2010); Harris, *supra* note 185 (defining the medical home as “another relatively new care model in which a single physician coordinates a patient’s treatment”).

187. Am. Acad. of Family Physicians et al., *Joint Principles of the Patient Centered Medical Home*, PATIENT-CENTERED PRIMARY CARE COLLABORATIVE, Feb. 2007, <http://www.pcpc.net/content/joint-principles-patient-centered-medical-home>.

entity.¹⁸⁸ Absent such a rationale as to why RHCs are incompatible with the medical home approach, it could be argued that this proposal merely seeks to maintain the status quo by perpetuating physician dominance and control over the provision of all health care. This traditional structure has reached its capacity limits and therefore fails to recognize the need for innovative new approaches to increase the capacity of the health care industry.¹⁸⁹ Second, it ignores the fact that a significant portion of the population that already is using, or is likely to use, RHCs is the portion that lacks a medical home to begin with.¹⁹⁰ In one study, RHC patients reported having a primary care physician only 38.7% of the time, far below the national average of 80.7%.¹⁹¹ This is strong evidence that independent NPs might be able to provide a medical home to those who do not otherwise have one with a physician—thus expanding access to a form of the medical home instead of interfering with it.¹⁹²

V. CONCLUSION

All remaining states with physician supervision and collaboration requirements should eliminate them and grant NPs the authority to practice independently. Mandatory physician involvement in NP practice is no longer necessary to ensure patient safety. Furthermore, as Barbara Safriet so astutely put it, “[t]hese provisions are more than benignly redundant, however; they are also harmful and costly.”¹⁹³ Supervision and collaboration requirements can disrupt efficient allocation of liability in the malpractice system, without an offsetting gain in ensuring adequate compensation to malpractice victims. Independent practice by NPs also facilitates innovative delivery-based reforms, such as RHCs, by eliminating a layer of regulatory complexity and lowering the cost of NP utilization. Mandating that NPs maintain and operate under a formal

188. Julie A. Muroff, *Retail Health Care: “Taking Stock” of State Responsibilities*, 30 J. LEGAL MED. 151, 163 (2009) (“Notwithstanding the tensions associated with these trends, there is support for the proposition that physician practices and retail health clinics can cooperate to benefit patient care.”).

189. See *supra* note 115 (discussing President Obama’s recognition of the need to “bend the . . . cost-curve” related to health care).

190. See Sage, *supra* note 7, at 514–15.

191. See Mehrotra et al., *supra* note 180, at 1276.

192. In drafting its set of comprehensive RHC regulations, Massachusetts demonstrated at least one strategy for addressing these concerns by requiring RHCs to provide patients who do not have primary care physicians with referrals to one, requiring RHCs to develop policies and procedures to identify, and possibly limit, the number of repeat encounters with individual patients, and mandating that RHC patients be provided with a copy of their medical records from the visit and/or that one be sent to the patient’s primary care physician. 105 MASS. CODE REGS. 140.1001(E)–(G) (2009).

193. Safriet, *supra* note 63, at 451.

relationship with a physician places both the NP profession and RHCs in a tenuous position. Given the importance of exploring new means of delivering health care to achieve expanded access and lower costs, the time has come to embrace multiple categories of independent practitioners. While independent practice authority for NPs is “certainly no panacea” for all of the problems weighing on the health care industry, it would certainly be a significant step toward opening new avenues for meaningful reform.¹⁹⁴

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194. See Sage, *supra* note 7, at 514.

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