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POWER ALLOCATIONS AND PROFESSIONAL HIERARCHY IN THE ILLINOIS HEALTH CARE SYSTEM

Patrick M. Callahan

I. INTRODUCTION

Nurse Sarah Dock, R.N., of Paducah, Kentucky, detailed her perspective on the proper relationship between nurses and doctors at the start of the 20th century.¹ Nurses are born and then trained, she explained, and women possess the qualities that “naturally make [them] superior to the average man for this work.”² According to Nurse Dock’s viewpoint, one of the most important components of the scope of her profession is the degree of deference nurses ought to give to medical doctors: the “first law and the very cornerstone” of a reliable nurse is obedience to them.³ A proper nurse will “obey without question,” and will not risk further professional opportunities by second-guessing the physicians’ expertise.⁴

Nurse Dock’s account of professional responsibility ought to be contrasted with Bernard Shaw’s 1906 play, “The Doctor’s Dilemma.”⁵ A commentary on modern Western medicine, Shaw’s protagonist, Dr. Colenso Ridgeon, is thrust into an ethical quandary whereby he must allocate scarce resources.⁶ He developed a new cure for tuberculosis, but only has enough of the remedy for one of his several patients.⁷ He is forced to choose between his poor professional colleague, and the husband of the woman he loves.⁸ The entire opus is a commentary on medical decision-making, and the frequent inability of doctors to sort through a complicated amalgam of motives and interests (“Can this man make better use of his leg than I of fifty pounds?”).⁹

Nurse Dock and Shaw’s Dr. Ridgeon evoke a perplexing question

1. Sarah E. Dock, *The Relation of the Nurse to the Doctor and the Doctor to the Nurse*, 17 *American Journal of Nursing* 394, 394 (1917).

2. *Ibid.*

3. *Ibid.*

4. *Ibid.*

5. “The Doctor’s Dilemma (play),” Wikipedia, [http://en.wikipedia.org/wiki/The_Doctor's_ilemma_\(play\)](http://en.wikipedia.org/wiki/The_Doctor's_ilemma_(play)) (last accessed March 3, 2010).

6. Bernard Shaw, “The Doctor’s Dilemma,” London: Nabu Press (1957).

7. *Ibid.*

8. *Ibid.*

9. Shaw, *supra* note 6.

that not only predated them, but also continued well beyond their time: what authority ought to be given to doctors? In stating that nurses ought to be subservient, Dock reveals an appreciation for doctors' exclusive authority and control in decision-making. Dr. Ridgeon's tumultuous moral escape implies that Dock's assumption of infallibility is not only misguided, but also somewhat dangerous. Is a doctor's unchecked power the proper balance of a well-established and efficient healthcare system? Or is it the reflection of a historically persistent hierarchy that threatens the welfare of consumers of medical services?

The debate over the proper relationship between healthcare professionals is played out among caregivers daily in hospitals and medical offices. Significantly, however, the debate also took root in professional advocacy. Professional groups – through individual care providers, their associations, and their review boards – are bitterly scrambling for control. State and federal associations are waging strategic campaigns to ensure the success and rank of their members. This article explores the ways in which the different professional groups attempt to affect power allocations.

The debate, too, has taken root rather significantly in American law. Through enabling statutes and practice acts, every state has taken at least remedial steps to define the proper balance of authority.¹⁰ In subsequent legislation, political leaders are writing into law more detailed and thorough resolutions to medical turf wars.¹¹ Public representatives – people who likely have no medical or healthcare experience beyond their attempts to regulate the system – are helping to design a medical hierarchy: they determine who can (or cannot) perform particular procedures, who has authority over whom, and what the penalties are for violating another group's power.¹²

Of course, the writing of a law is only the beginning. Inseparable from the existence of laws is the need to litigate them. Professional associations, individual practitioners, patients, and state regulators often turn to the courts to settle disputes that reinforce or induce power allocations. With the resolution of each suit, courts are affecting the hierarchy – either by modifying it, or reinforcing professional groups' preexisting positions within it.

Lastly, the inarguably most important component of this article is its

10. Edward P. Richards, "The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing board Regulation of Physicians in ERISA-Qualified Managed Care Organizations," 8 *Annals of Health Law* 201 (1999).

11. Richards, *supra* note 10.

12. *Ibid.*

analysis of the implications of these power allocations for patients. Healthcare systems are only “good” inasmuch as they serve their ailing consumers. Every power allocation made through advocacy, legislation, and litigation says something about future patients’ healthcare experiences and opportunities. A persistent justification for the allocation of power is an interest in quality control; authority is frequently given to one professional group exclusively so that they may ensure patients receive the highest quality services. However, power may also be allocated to particular professional groups to address patients’ inability to access the services through its more typical means; by dispersing the power to an additional group, patients may be able to obtain care where they otherwise could not. Further, exclusive power allocations can drive up costs, burdening patients who purchase their services, if not preventing them from receiving care altogether. This paper argues that the most appropriate hierarchy in the healthcare system is one that maximizes the patient population’s position relative to three factors that severely dictate patient experiences within the system: quality, access, and cost.

II. SOURCES OF AUTHORITY

The professional hierarchy in healthcare is generally established when participants in the healthcare realm work to define the practice of medicine. For legal purposes, the practice of medicine refers to the scope of services that may be rendered exclusively by licensed physicians.¹³ Defining the practice more specifically is a process of boundary setting, whereby various professions attempt to categorize what qualifies as medicine, and what does not. The process is both imperfect, and continuous.¹⁴ The process often fails to account for overlapping competences in different professional groups.¹⁵ Unfamiliar legislators and judges may obfuscate the particularities of the nature of diagnoses and treatments.¹⁶ As new procedures, technologies, and information are introduced into the healthcare forum, the authority to govern them and their uses is shaped through a range of modes: 1) legislative activism, 2) government administration, 3) professional lobbying and advocacy, and 4) litigation. First is a discussion on legislative and professional efforts to define the practice of medicine; these are preliminary sources of authority that place healthcare actors in a hier-

13. Barry Furrow, et al., *Health Law, Cases, Materials and Problems* 150 (6th ed. 2008).

14. Lori Rinella, *The Use of Medical Practice Guidelines in Medical Malpractice Litigation – Should Practice Guidelines Define the Standard of Care?*, 64 UMKC L. Rev. 337 (1996).

15. Furrow, *supra* note 13, at 150.

16. *Ibid.*

archy. The following section will discuss how this hierarchy is regularly reinforced in case law.

A. Legislative Sources of Authority

Every state has, at a most basic level, health profession practice acts.¹⁷ Written under the authority of the state's police powers delineated by the United States Constitution, these acts recognize the legitimacy of various health practices (medical and non-medical), define the scope of the practices, and sometimes create regulatory boards with the authority to continue shaping the legal framework of the practice of the profession.¹⁸ These practice acts enable professional groups to defend their expertise; in other words, the acts enable them to claim healthcare "turf" as belonging to them.¹⁹ By describing standards, and setting out penalties for failing to meet the standards, the practice acts are granting the named professionals the authority to regulate the type of care patients may receive, and the ways in which they may receive it.²⁰ Similarly, it enables groups to assert under color of law that turf does not belong to particular other professions.²¹ Health practice acts directly allocate power to types of health professionals, and can be used to establish hierarchy and authority in the general healthcare system. It is the foundation upon which all further power allocations are made.

One of the biggest sources of hierarchy in health profession acts is the licensing requirement states use to limit access to those professions. Licenses are required of practitioners before they can legally participate in their profession.²² Once licensed, the licensees must confine their behavior within the perimeters laid out by their relevant practice acts.²³ Licensees who fail to comply are subjected to a host of disciplinary actions ranging from simple reprimands to binding orders to discontinue professional practice altogether.²⁴ Licenses do not just bestow upon its holder the permission to participate in the profession: they carry with them substantial and serious obligations, as well.

17. Rinella, *supra* note 14.

18. James W. Hilliard & Marjorie E. Johnson, *State Practice Acts of Licensed Health Professions: Scope of Practice*, 8 DePaul J. Health Care L. 237, 237 (2004).

19. Hilliard, at 251.

20. *Id.* at 252.

21. *Id.*

22. Elizabeth Harrison Hadley, *Nurses and Prescriptive Authority: A Legal and Economic Analysis*, 15 Am. J. L. and Med. 245, 248 (1989); *see also* Illinois Medical Practice Act, 225 ILCS 60 (1987).

23. Hadley, at 248.

24. *Id.*

By acquiring and following the proscriptions of a professional license, individual caregivers themselves reinforce the power allocations made by the practice acts. This is especially true where they explicitly designate caregivers' positions relative to one another. For example, the license to practice medicine is a significant piece of ammunition in the fight for turf among the healthcare profession.²⁵ Only individuals possessing the degrees of doctor of medicine, doctor of osteopathy, and doctor of chiropractic are eligible to hold a medical license in the state of Illinois.²⁶

In the Medical Practice Act, specific references are made to a duty imposed on medical licensees to adequately collaborate with and provide medical direction to licensed advanced practice nurses, as medically necessary within a given context.²⁷ Further, Section 54.5 of the Act provides medical licensees the power to delegate to other types of licensees.²⁸ First, the Act specifies that physicians with medical licenses "may delegate care and treatment responsibilities to a physician assistant" in accordance with the Physician Assistant Practice Act of 1987.²⁹ The Act then states that physicians licensed to practice medicine may "collaborate with an advanced practice nurses" – like certified nurse practitioners, certified nurse midwives, and clinical nurse specialists – according to the Nursing and Advanced Practice Nursing Act.³⁰ Collaboration is dependent upon the physician's formulation and approval of orders or guidelines, provision of direction and consultation, and his or her availability through telecommunications for consultations, complications, referrals, and emergencies.³¹ This same arrangement is detailed for certified registered nurse anesthetists, as well.³² Physicians supervising advanced practice nurses are re-

25. See Cheryl Clark, "Doctors Sue to Stop Unsupervised Nurse Anesthetists from Administering Anesthesia," HealthLeaders Media, <http://www.healthleadersmedia.com/content/PHY-245956/Doctors-Sue-To-Stop-Unsupervised-Nurse-Anesthetists-from-Administering-Anesthesia.html> (last accessed March 3, 2010), and *American Medical Association v. Weinberger*, 522 F.2d 921 (7th Cir. 1975) (involving a suit over the state's reform to utilization review practices).

26. 255 ILCS 60/13. While Illinois recognizes chiropractors as medical practitioners, other states do not.

27. See 225 ILCS 60/54.5.

28. 225 ILCS 60/54.5(a).

29. *Id.*

30. *Id.*

31. *Id.* The language of the statute's provision reading "joint formulation and joint approval of orders or guidelines with the advanced practice nurse" may initially confuse the power allocation being made. Medical licensees possess the authority to make and approve of orders and guidelines independently of advanced practice nurses. Here, the Act is essentially conveying the requirement that advanced practice nurses may not formulate or approve of orders or guidelines without the consent and authority of a medical licensee. The only burden being placed on medical licensees is the expectation that they make use of their power by furnishing this consent and authority where appropriate. This is further proved by the reminder § 54.2(a) that the Act is not to be construed so as to limit a medical licensee's duties or powers to delegate to licensed practical nurses, registered professional nurses, or other personnel.

32. 225 ILCS 60/54.2(a). It is important to note that the Medical Practice Act does not require a physician

quired to have access to the medical records of all patients attended to by those nurses.³³ The Act goes on to state that it is not to be construed so as to limit the delegation powers or the duties to licensed practical nurses, or registered professional nurses.³⁴ Despite all of the supervisory powers medical licensees are granted over other non-medical licensees, the Act further distinguishes medical licensees by granting them immunity from suits stemming to the performance of non-medical licensees who appear to be sufficiently competent.³⁵ The only restrictions for medical licensees appearing within the entirety of the Act are those imposed by the Illinois state government or the medical professions themselves.³⁶

The licensing requirements for non-medical caregivers reinforce the Medical Act's power allocations. While non-physician providers play an imperative role in the provision of medical services, they are not practicing medicine in the legal sense; instead, they partake in their own separate licensure programs. Through them, they are certified to practice their particular field – something that does not qualify as “medicine”.³⁷ Nurses, for example, do not practice medicine: they practice nursing. Further, they do so under the supervision and control of the medical practitioners.³⁸ In the Nursing and Advanced Practice Nursing Act (“Nursing Act”), many provisions refer to the requirement that licensed nurses or advance practice nurses operate with specific and continuous oversight by physicians licensed under the Medical Practice Act of 1987. As early as the definitions section of the Nursing Act, medical licensees are allocated power over the nursing licensees: “registered professional nursing practice” includes as one of its basic tenets the administration of medications and treatments only as prescribed by a physician licensed to practice medicine, a licensed

to discuss and agree to an anesthesia plan when an anesthesiologist is providing the anesthesia services; that duty is only imposed when a certified registered nurse anesthetist renders the services. *Pollack v. Department of Professional Regulation*, 854 N.E.2d 721 (Ill. App. Ct. 2006). Currently, however, nurse anesthetists are pushing for additional independence from physicians. Amy Lynn Sorrel, “Scope of practice expansions fuel legal battles,” *American Medical News*, <http://www.ama-assn.org/amednews/2009/03/09/prl20309.htm> (last accessed March 1, 2010).

33. 225 ILCS 60/54.5

34. *Id.*

35. See 225 ILCS 60/23. “Immunity from prosecution. Any individual or organization acting in good faith, and not in a willful and wanton manner, in complying with this Act by providing any report or other information to the Disciplinary Board or a peer review committee, or assisting in the investigation or preparation of such information, or by voluntarily reporting to the Disciplinary Board or a peer review committee information regarding alleged errors or negligence by a person licensed under this Act, or by participating in proceedings of the Disciplinary Board or a peer review committee, or by serving as a member of the Disciplinary Board or a peer review committee, shall not, as a result of such actions, be subject to criminal prosecution or civil damages.”

36. For examples, see 225 ILCS 60/6 and 225 ILCS 60/10.

37. See 225 ILCS 65/50-10.

38. 225 ILCS 60/54.5.

dentist, a licensed podiatrist, or a licensed optometrist.³⁹ The Nursing Act explicitly defines the scope of particular types of nursing licenses, and it notes that Licensed Practical Nurses are responsible for the tasks delegated to them by higher-ranking nurses, as well as physicians, dentists, and podiatrists.⁴⁰ To a lesser degree, the scope of practice for Registered Nurses also references the supervisory powers possessed by medical licensees, where registered nurses develop plans of nursing care to be integrated with the strategies, regimens, and prescriptions authorized by medical licensees and other healthcare professionals.⁴¹ While medical licensees in the Medical Practice Act are only accountable to themselves and the state government, the Nursing Act demonstrates that nurses are accountable to themselves, the state, and to physicians.

The Nursing Act constructs the power allocations much more clearly when it details the relationship between medical licensees and advanced practice nurses. To engage in clinical practice, all advanced practice nurses must compose a written collaborative agreement with a physician or podiatrist.⁴² The agreement must describe the nature of the working relationship between the advanced practice nurse and the medical licensee.⁴³ Further, the agreement must specify which particular procedures the nurse may only perform under direct supervision.⁴⁴ The Nursing Act includes additional provisions stating that the collaborating medical licensees control the filing and termination of the notice of delegation of prescriptive authority to the Department of Professional Regulation.⁴⁵ Further, as a component of the written agreements, the medical licensee is not required to delegate prescriptive authority to the advanced practice nurse, but may exercise the discretion to do so.⁴⁶

The Board of Nursing, comparable in scope to the physicians' medical board, is required to submit all proposed rules, amendments, second notice materials, adopted rule or amendment materials, and policy statements concerning advanced practice nursing to the medical board for review and comment.⁴⁷ This Act constitutes the legal and professional foundation of advanced practice nursing in Illinois; even here, it allocates

39. 225 ILCS 65/50-10.

40. 225 ILCS 65/55-30(a)

41. 225 ILCS 65/60-35.

42. 225 ILCS 65/65-35.

43. *Id.*

44. *Id.* The collaboration requirements mirror the arrangement for the same types of parties detailed in the Medical Practice Act. Compare 225 ILCS 65/65-35 and 225 ILCS 60/54.5.

45. 225 ILCS 65/65-35.

46. 225 ILCS 65/50-65.

47. 225 ILCS 65/50-65(d)

power in a way that reinforces advanced practice nurses' subservient role. Though trained to perform many of the same tasks as physicians, they remain dependent upon the physician's authority. Advanced practice nurses are not legally conceptualized as "medical" in nature, so they require the approval and supervision of those practitioners who are.

B. Professional Sources of Power

Within the hierarchical context created by legislative allocations of power, professional groups will lobby for additional authority. The successes and failures of the different professional groups in the debates over practice scopes are encumbered with substantial hierarchical implications. As such, the groups go to great lengths to ensure their successes. Major campaigns are launched for the specific purpose of advancing professional groups' relative status and dominion.

In the early 19th century, medical societies were organized for the sole purpose of obtaining a state-sanctioned power to control medicine generally.⁴⁸ As the push for reliance upon the scientific method gained strength, doctors subscribing to it gained the right to mandate medical licenses as a prerequisite for the practice of medicine.⁴⁹ This laid the foundation for the legislative allocations of power, as detailed in the previous section. As demonstrated in the SOPP, professional campaigns for power continued to the present day. The American Medical Association (AMA) is a frequent architect of these movements.⁵⁰ In the early and mid 20th century, Morris Fishbein, the Secretary of the AMA, led a 50-year campaign against chiropractors, saying they were like "rabid dogs" because they were "playful and cute . . . but killers."⁵¹ The AMA characterized chiropractors as unscientific and money-driven.⁵² Motivated by fears that chiropractors would acquire the power to substantially influence the practice of medicine, the AMA created the Committee on Quackery in 1971.⁵³ Aided by the medical community's immense legislative power, the Committee fought vigorously to bar chiropractors from obtaining coverage un-

48. "The History of Medicine 1800-1850," Wellness Directory of Minnesota, <http://www.mnwelldir.org/docs/history/history03.htm> (last accessed March 1, 2010).

49. *Id.*

50. The AMA is motivated by its view that "the vulnerable layperson requires protection from professional experts . . . [and is] ignorant . . . even as to which profession . . . to consult." Walter J. Wardwell, *Chiropractors: Challengers of Medical Domination*, 2 Res. Soc. Health Care 207, 208 (1981).

51. "Chiropractic History: The AMA vs. Chiropractic," <http://www.svpvriil.com/amavchir.html> (last accessed March 1, 2010).

52. "Chiropractic History: The AMA vs. Chiropractic," <http://www.svpvriil.com/amavchir.html> (last accessed March 1, 2010).

53. *Id.*

der Medicare, to divide chiropractic professional associations, to enable state medical associations in their efforts to use legislation against the chiropractic practice, and to prevent the formation of a chiropractic accreditation agency.⁵⁴ Not until the introduction of antitrust lawsuits against medical professional groups did the AMA reduce its diligent protest of the chiropractors' possession of a position in the "medical" field. However, the AMA continues to fight chiropractors under the notion that it is unsafe and provides few medical benefits.⁵⁵ Many states, to this day, do not allow chiropractors to call themselves physicians; they follow a licensing program separate from physicians, and are those not considered medical licensees.⁵⁶ The AMA fight against the chiropractic practice demonstrates the ways in which professional advocacy can be used to address hierarchy in the healthcare system. The AMA's lobbying for exclusive control reflects the historical struggle to acquire authority found in the activities of professional groups today.

In 2004, the American Association of College of Nursing's Task Force on the Practice Doctorate of Nursing issued a position statement recommending that the possession of a doctorate of nursing practice, or D.N.P., be the minimum education level for entry into advanced nursing practice.⁵⁷ Physicians' groups became concerned that the doctor-nurse title may confuse patients about the educational level and medical expertise of their caregivers. In response, the AMA formed a coalition of national medical specialty organizations and state medical societies, called the Scope of Practice Partnership (SOPP). Members of the SOPP are collecting data on licensure requirements, educational preparation, and scope of practice legislation from each of the fifty states.⁵⁸ The partnership is easily comparable to the AMA's attack on chiropractic practice. They seek to address the threats to medical licensees' authority posed not only by nurses and advanced practice nurses, but other professional groups like optometrists and psychologists.⁵⁹ The stated purpose is to develop model legisla-

54. *Id.*

55. *Id.*

56. Examples include California, Texas, and Maine.

57. "Scope of Practice Partnership to Address 'Doctor-Nurse' Trend," American Academy of Family Physicians, <http://www.aafp.org/online/en/home/publications/news/news-now/professional-issues/20060403scope.html> (last accessed March 1, 2010).

58. *Id.*

59. Michael Devitt, "AMA Creates 'Partnership' to Limit Other Providers' Scope of Practice," <http://www.dynamicchiropractic.com/mpacms/dc/article.php?id=51219> (last accessed March 1, 2010). In a commentary from the chair of the AMA Board of Trustees, attempts made by optometrists and psychologists to expand the scope of practice were referred to as "assaults on the practice of medicine." Edward L. Langston, "Scope of practice: Need for continuing dialogue," <http://www.ama-assn.org/amednews/2008/06/02/edca0602.htm> (last accessed March 1, 2010).

tion that would reinforce existing power disparity, using the lobbying strengths of the medical associations.⁶⁰ Currently, non-medical licensees face a number of legal constraints likely constructed at the urging of medical physicians; these include: laws relating to the unauthorized practice of medicine, limitations on direct reimbursement to nonphysician providers, laws that limit nonphysician providers' power to prescribe, and policies excluding them from admitting practices at particular health care institutions. The SOPP is a continuation of the efforts that led to these legal barriers imposed upon nonmedical licensees.

In early 2006, a number of diverse health professions combined efforts to fight the AMA's campaigns for increased control over medicine, and they formed the Coalition for Patients' Rights (CPR).⁶¹ The Coalition is made up of thirty-five professional associations whose members, mostly nurses and psychiatrists, are regularly excluded from medical licensing statutes and want more independence from medical licensees.⁶² CPR "counters claims by medicine that all health professionals should be supervised by physicians and regulated by entities comprised of physicians."⁶³ The CPR objects to the Partnership's creation of legislative reports that attempt to de-legitimize non-medical health professions, and to the Partnership's campaign against state and federal legislation addressing the practice of other professional groups.⁶⁴ It attacks the SOPP as "a method to constrain nurse practitioners and other providers who are not

60. "Scope of Practice Partnership," *supra* note 57.

61. Linda L. Lindeke, & Karen KellyThomas, "The SOPP and the Coalition for Patients' Rights: Implications of Continuing Interprofessional Tension for PNs," 24 *J of Pediatric Health Care* 62, 63 (2010).

62. *Id.* The members are: American Academy of Nurse Practitioners, American Association for Marriage and Family Therapy, American Association of Colleges of Nursing, American Association of Critical-Care Nurses, American Association of Naturopathic Physicians, American Association of Nurse Anesthetists, American Association of Acupuncture and Oriental Medicine, American Association of Occupational Health Nurses, American Chiropractic Association, American College of Nurse-Midwives, American College of Nurse Practitioners, American Nephrology Nurses Association, American Nurses Association, American Occupational Therapy Association, American Physical Therapy Association, American Psychological Association, American Psychiatric Nurses Association, American Speech-Language Hearing Association, Association of Nurse in AIDS Care, Association of Perioperative Registered Nurses, Association of Rehabilitation Nurses, Association of Schools of Allied Health Professions, Association of Women's Health, Obstetric and Neonatal Nurses, California Optometric Association, Emergency Nurses Association, Hospice and Palliative Nurses Association, Integrated Health Policy Consortium, National Association of Clinical Nurse Specialists, National Association of Nurse Practitioners in Women's Health, National Association of Pediatric Nurse Specialists, National Association of Nurse Practitioners in Women's Health, National Association of Pediatric Nurse Practitioners, National Council of State Board of Nursing, National League for Nursing, National Nursing Centers Consortium, National Organization of Nurse Practitioners Faculties, Oncology Nursing Society, Preventive Cardiovascular Nurses Association, and Wound Ostomy and Continence Nurses Society.

63. Lindeke, *supra* note 61.

64. *Id.*

physicians.”⁶⁵ The dynamic is perceived as being physicians versus all other practitioners. The medical licensees want control over the other professions, and the ability to supervise their work; the members of the Coalition want more independent authority, or, conversely, to be subjected to fewer controls from medical licensees when providing care to patients. The groups have launched extensive campaigns in every state to gain further power allocations from those who are in the position to give it to them. Both the CPR and the SOPP are continuing the historical fight for power within the healthcare hierarchy.

C. Judicial Allocations of Power

A cynical observer knows that where there are disagreements, there are opportunities for lawsuits. This complicated struggle for power among the health professions is no exception. Quite frequently, individual practitioners, professional associations, and state regulators find themselves in the courtroom challenging healthcare power allocations.⁶⁶ They are seeking the right to control particular procedures, treatments, diagnoses, or entire corners of the medical market⁶⁷. Like Nurse Dock in 1917, courts generally submit to the wishes of the medical licensees; further, they broadly defer to medical regulatory boards seeking to prohibit the delivery of particular health care services by persons holding a different license, or holding no license at all.⁶⁸

An illustration of judicial discretion used to reinforce medical licensees' control is found in Am. Med. Assoc. v. Weinberger.⁶⁹ There, the AMA (along with some patients, and some beneficiaries of Medicare and Medicaid) sought to enjoin the Secretary of Illinois' Department of Health, Education and Welfare from changing the utilization review process on the grounds that it would interfere with the doctor-patient relationship.⁷⁰ The AMA argued “the new regulations which mandate immediate review of the doctor's decision to admit a patient have the effect of allowing [the Department] to interfere with a function and duty traditionally reserved to

65. *Id.* at 64.

66. See State Bd. of Nursing v. Ruebke, 913 P.2d 142 (Kansas 1996) (holding that a practicing lay midwife was not practicing medicine without a license), State Bd of Registration for the Healing Arts v. McDonagh, 123 S.W.3d 146 (Mo. 2003) (involving a suit over an osteopathic physician's use of alternative medical treatments in his family practice), and Am. Med. Assoc. v. Weinberger, 522 F.2d 921 (7th Cir. 1975) (involving a suit over the state's reform to utilization review practices).

67. *Id.*

68. Hilliard, *supra* note 18.

69. Am. Med. Assoc. v. Weinberger, 522 F.2d 921 (7th Cir. 1975)

70. *Id.* at 921.

qualified medical professionals.”⁷¹ Ultimately, the appellate court upheld the lower court’s grant of the injunction in favor of the AMA.⁷² The appellate court found that the lower court did not err in considering that the new regulations may have the effect of “directly influencing a doctor’s decision on what type of medical treatment will be provided, [and] thus directly interfering with the practice of medicine.”⁷³ The court’s decision was, to a significant degree, grounded in the plaintiff-professional association’s desire to remain in control of the way in which medicine is practiced. In doing so, however, the court also acknowledged that the state retains some powers to regulate medical services.⁷⁴ This decision reinforces the notion that the medical licensees, while ranking high in the healthcare hierarchy, are still accountable to another entity. There is a balance in the powers to be allocated to the medical profession, and those that are to remain in the hands of the state regulators.

Additionally, patients themselves may help to alter the allocation of power through malpractice claims. These lawsuits often ask courts to settle disputes over the standard of practice. The effects of the suits can be to either indirectly affirm physician control over medical procedures, or to absolve the physician and place liability in the hands of another practitioner for whom he is not responsible. One such case illustrating this is Pollachek v. Dep’t of Prof’l Regulation.⁷⁵ There, the plaintiff, a certified registered nurse anesthetist (CRNA), sought to permanently enjoin the Illinois Department of Professional Regulation from enforcing § 1305.45(e) of its regulation on Delivery of Anesthesia Services by a Certified Registered Nurse Anesthetist.⁷⁶ The regulation specified that a CRNA may only provide anesthesia services in a physician’s office if that physician has training and experience in the delivery of anesthesia services to patients.⁷⁷ The appellate court reversed the lower courts’ order enjoining the enforcement of the section. In doing so, it reasoned that the defendant-Department behaved neither arbitrarily nor capriciously.⁷⁸ The court deferred to the Department’s Director’s testimony, which was largely grounded in an interest

71. *Id.* at 925.

72. *Id.* at 927.

73. *Id.* at 925.

74. The court references a series of cases where the procedures by which the federal government was allowed to determine whether or not to reimburse a practitioner: Johnson’s Prof’l Nursing Home v. Weinberger, 490 F.2d 841 (5th Cir. 1974), and Assoc. of Am. Physicians & Surgeons v. Weinberger, 395 F. Supp. 125, No. 73 C 1653 (N.D. Ill. 1975).

75. Pollachek v. Dep’t of Prof’l Regulation, 854 N.E.2d 721 (Ill. App. Ct. 2006)

76. *Id.* at 723.

77. *Id.* at 724.

78. *Id.* at 736.

in ensuring patients receive the utmost quality of care possible, with as few risks to their welfare as possible.⁷⁹ By the court's estimate, the regulations were rational, and consistent with the interests of the public's health and welfare.⁸⁰ The case is not only significant because of its outcome, but also because of its reasoning. In the name of public interest, the court affirmed physician control over nurse anesthetists. Rather than concerning itself with cost or access (interests that were only casually mentioned), the court put all its stock in quality control; further, its best estimate of quality protection involved reinforcing the superior status possessed by physicians over non-medical licensees.

These and other decisions reinforce the notion that the system is one of power allocations, and that the outcomes of those allocations are significant for the patient population. Courts are given the opportunity to set standards of practice, examine the impact a particular arrangement within the hierarchy has on the public, and define the scope of healthcare professions according to their licenses and the needs of the system. Litigation is an important component of the healthcare hierarchy, and its impact upon the patient population is substantial.

III. THE EFFECTS OF POWER ALLOCATIONS ON THE HEALTHCARE SYSTEM

Through legislation, professional advocacy, and litigation, power allocations are constantly being addressed and altered. The professional groups' relative position to one another, and the control and authority that comes with those positions, significantly impacts the patient population. The effects can best be understood according to three patient interests: quality, cost, and access.

A. Quality

One of the primary justifications a professional group offers when seeking power in healthcare is an interest in maximizing the quality of services.⁸¹ Practitioners charged with exceeding the designated scope of their profession will regularly defend themselves by invoking their ability to sufficiently match the quality demanded by the existing standards of practice.⁸² A fixation on quality as the standard against which power is allo-

79. *Id.* at 736-37.

80. *Id.* at 737.

81. See Pollacheck v. Dep't of Prof'l Regulation, 854 N.E.2d 721 (Ill. App. Ct. 2006), and Assoc. of Am. Physicians & Surgeons v. Weinberger, 395 F. Supp. 125, No. 73 C 1653 (N.D. Ill. 1975).

82. *Id.*

cated is certainly admirable. The consequence of this fixation is reinforcement of medical licensees' control over other professional groups. Physicians are the presumed superlative providers, and allocations are made accordingly. Research indicates, however, that other professional groups are sometimes able to provide comparable care – perhaps even better care – than physicians.

Advanced practice nurses are now managing to compete with the quality of services provided by medical licensees. Based on a review of 31 studies comparing doctors to nurse practitioners, nurse practitioners are found to be at least as capable as physicians with regard to many primary care functions.⁸³ Further, physician assistants, nurse practitioners, and certified nurse midwives, within the limits of their training, were also found to provide “medical care similar in quality to that of physicians and at less cost.”⁸⁴ Nurse midwives, in particular, perform exceedingly well when compared to physicians. When examining fetal, prenatal, perinatal, and maternal mortality rates, nurse midwives perform just as highly.⁸⁵ With regard to low risk pregnancies, nurse midwives actually perform better statistically.⁸⁶ Furthermore, nurse practitioners are able to dedicate more time to patient care and communication than physicians can. Nurse practitioners possess better interpersonal skills, spend more time talking to patients, and provide better emotional support.⁸⁷ As a result, patients of nurse practitioners are better informed of ameliorative activities and the importance of exercise than physicians' patients.⁸⁸

Unfortunately, because of the hierarchy of power in the American healthcare system, nonphysician professional groups are underutilized. Upon the advent of a generous health insurance system, physicians were almost automatically reimbursed for whatever care they deemed necessary.⁸⁹ This practice had the affect of leaving physicians to determine what constitutes proper medical care.⁹⁰ The judicial system reinforced physi-

83. Patricia A. Prescott & Laura Driscoll, *Nurse Practitioner Effectiveness: A Review of Physician-Nurse Comparison Studies*, 2 *Evaluation & Health Profs.* 387, 388-389 (1979).

84. Edward S. Sekscenski et al., *State Practice Environments and the Supply of Physician Assistants, Nurse Practitioners, and Certified Nurse-Midwives*, 331 *New Eng. J. Med.* 1266, 1266 (1994).

85. William J. Hueston & Mary Rudy, *A Comparison of Labor and Delivery Management Between Nurse Midwives and Family Physicians*, 98 *Annals Internal Med.* 993, 995 (1983).

86. *Ibid.*

87. Alice N. Bessman, *Comparison of Medical Care in Nurse Clinician and Physician Clinics in Medical School Affiliated Hospitals*, 27 *J. Chronic Diseases* 115, 124 (1974).

88. Beverly C. Flynn, *The Effectiveness of Nurse Clinicians' Service Delivery*, 64 *Am. J. Pub. Health* 604, 610 (1974).

89. E. Haavi Morreim, “Redefining Quality by Reassigning Responsibility,” 20 *Am. J.L. & Med.* 79, 80 (1994).

90. *Id.*

cians' interests in dictating standards as they became legally responsible for their own mistakes and the mistakes of the nonphysician care providers with whom they worked.⁹¹ Quality care, over time, became what medical licensees decided it was. Importantly, as power allocations were made, the standards of care were disproportionately within the exclusive authority of physicians and they were enforceable against the other professional groups.

As shown in the Illinois statutes, nursing is still conceptualized as the second-tier profession to medical licensees. Their work is dependent upon the physicians' use of their delegation powers. As early as 1972, researchers found that physicians were not delegating services to nurses as much as they admitted they could.⁹² This is consistent with medical licensees' demands for exclusive authority to provide particular medical services. The allocation of exclusive authority to medical licensees must be reconsidered in light of the fact that "alternative providers can safely perform many health care tasks that they are currently prohibited from performing by state laws . . . and that alternative providers can offer higher quality services than physicians in certain circumstances."⁹³ Aided by further research, the institutions and individuals in charge of settling power disputes must sharply seek out the decisions that enable all of the professional groups capable of delivering quality care. Where nonphysicians are capable of providing the same quality as physicians, equal powers must be allocated to both groups. Where physicians remain the only competent group, their exclusive authority must be upheld. Allocations of power within the healthcare system must be made with an eye toward maximizing access to quality care.

B. Cost

The often forgotten effect of allocating exclusive power to a professional group is the imposition of additional or higher costs. A cursory glance at antitrust law validates the time-tested principle that markets with fewer competitors have higher prices than markets with more competitors.⁹⁴ Combining this principle with the costs of medical educations and high compensation expectations, exclusive authority in healthcare can

91. *Id.* at 83.

92. Eric L. Herzog, "The Underutilization of Nurses and Physician Assistants in Ambulatory Care," (Robert Wood Johnson Foundation, Working Paper, 1974).

93. Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 *Hous. L. Rev.* 1273 (1996).

94. Andrew I. Gavil, et al., *Antitrust Law in Perspective* 2-4 (2d ed. 2008).

drive up costs rather significantly.⁹⁵ Medical licensees generally pay substantially more for their education than do non-medical licensees.⁹⁶ Further, they spend more time obtaining an education – one that is socially perceived as being more arduous than the programs for other caregivers. Consequently, costs are inevitably higher when physicians are granted the exclusive control over procedures, treatments, diagnoses, and other professionals. While the scope of practice limitations are intended to protect quality, they must be measured against the economic burdens they impose.

Comparing once again nurse midwives and physicians, the data suggests that nurse midwives are able to reduce healthcare expenditures. Looking at the care provided by midwives and physicians for similar patient populations, midwives' patients have the same health outcomes as the physicians' patients do, and midwives use fewer pharmaceuticals, order fewer tests and fewer cesarean sections.⁹⁷ Physicians, then, are providing more service than are necessary. Research like this is even more important when taking into account the relative cost: nurse midwives can cost half as much as their physician counterparts.⁹⁸ Thus, the costs necessary to achieve the care patients need are much lower under nurse midwives. With increased delegation of authority to midwives, further savings could be realized. Further, increased delegation to nonphysicians can lower costs across the entire healthcare system. Increased usage of nurse practitioners could save \$6.4-8.75 billion annually.⁹⁹ Significantly, approximately 75-85% of adult primary care could be safely deferred to caregivers from alternative health professions.¹⁰⁰ Certainly, physicians have a broader expertise, and tort law requires nonphysicians to refer complicated patients to the more qualified medical licensees. However, this research indicates that the lowering of costs can be achieved in some areas through more delegation to non-medical caregivers.

Well-intentioned quality concerns allocate power in such a way that places more patients directly in the hands of physicians; given the cost-effectiveness and the sufficiency of quality found in other professional

95. Maggie Mahar, *Money-Driven Medicine* (1st ed. 2006).

96. Compare "Medical Student Education: Costs, Debt, and Loan Repayment Facts," Am. Assoc. of Med. Colleges, <http://www.aamc.org/programs/first/debtfactcard.pdf> (last accessed on April 10, 2010), and "2009-10 College Prices," CollegeBoard, <http://www.collegeboard.com/student/pay/add-it-up/4494.html> (last accessed April 10, 2010).

97. "Birth of the Modern Midwife," <http://iml.jou.ufl.edu/projects/spring2000/vanwagner/health.htm> (last accessed 10 February 2010).

98. *Id.*

99. Len M. Nichols, *Estimating Costs of Underusing Advanced Practice Nurses*, 10 *Nursing Econ.* 343, 350 (1992).

100. Linda H. Aiken & William M. Sage, *Staffing National Health Care Reform: A Role for Advanced Practice Nurses*, 26 *Akron L. Rev.* 187, 196 (1992).

groups, however, power ought to be allocated differently. Patient access to care is largely dependent upon affordability; regulators within the healthcare system ought to take into account how access is affected by the ways in which they impose or reduce costs through their allocations of power.

C. Access

Certainly, patients' access to medical care can be diminished when power allocations cause prices to increase. However, access can also be a matter of geography. Suburban and rural communities may not have within a reasonable distance the types of caregivers they require. Medical specialists, other advanced practice caregivers, and complex healthcare facilities and technologies may all be out of reach because the market demand for them may be too low in a particular region. Alternatively, urban cities have sufficient market demand to offer a more comprehensive range of services and professionals.¹⁰¹ Differences in access may necessitate deviations from traditional notions of hierarchy.

In the landmark case Sermchief v. Gonzales, the Missouri Supreme Court correctly allocated power. There, the Court looked at a petition for declaratory judgment from an agency serving low-income and rural populations.¹⁰² The East Missouri Action Agency delivered care to underserved communities through a heavier reliance on advanced practice nurses.¹⁰³ The patients they served often lacked health insurance and did not have the means to pay for physicians' costs out of pocket.¹⁰⁴ The Agency used less expensive, competent nurses to meet the patients' needs. Against a challenge from Missouri's state medical board, the Supreme Court upheld the Agency's practices. In doing so, the Court likely chose to ignore the legal issues presented by the nurses' practicing without the direct supervision of a physician. It cited a lack of evidence of harm, and a necessary trend toward broadening the scope of nursing as a profession.¹⁰⁵ This case is unique in that it properly considers patient access to care as the guiding criterion. It is this type of power allocation that needs to permeate the rest of the healthcare system. As iterated previously, nurse midwives perform well when compared to physicians; this is even true when looking at un-

101. Cite. One should note that the mere offering of a service might at times be insufficient, if the demand for the service exceeds its supply.

102. Sermchief v. Gonzales, 660 S.W.2d 683 (Mo. 1983).

103. *Id.*

104. *Id.* at 684.

105. *Id.* at 689.

derprivileged patients, in spite of the fact that such patients present a “greater risk for obstetric complications because of the relative nutritional and psychosocial deprivation” stemming from their socioeconomic status.¹⁰⁶ Seeing that advanced practice nurses can provide the same quality care as physicians – and at a lower cost – access can be safely promoted by maximizing access to these nonphysician providers. Where geographic and socioeconomic hurdles limit patient access to medical licensees, other qualified professional groups must be allowed to step in and meet the demand for services. Depending upon how power is allocated to these nonphysician groups, access can be severely inhibited or expanded. Those in the position to regulate the professional hierarchy in the healthcare system ought to seek out resolutions that favor patients’ access to care.

IV. CONCLUSION

Bernard Shaw’s play and in Nurse Dock’s account of professional responsibility inadvertently expose an issue that continues to permeate the American healthcare system. Each told a diametrically opposed version of how much faith should be placed in the physicians’ hierarchy. Certainly, when Nurse Dock detailed the deference owed to physicians, she was well founded: physicians have a thorough education, and a proper medical system will place a lot of faith in their ability to provide medical services. For these and other reasons, physicians demand to be the central authority on the provision of medical services. However, as shown in Shaw’s play and in this article, medical licensees are not without their limitations. As such, doctors and nonphysician providers are in a persistent and comprehensive bid for power.

Health professional groups are using a number of means to acquire power and reinforce their relative position within the system. Through legislative acts, professional advocacy, and litigation, each group is actively working to impose its authority to place itself alongside or above other care providers. The battle is both local and national; it is incremental and dramatic; and, undoubtedly, the battle is important for consumers of medical services.

Every patient experience is dictated by the resolutions (or lack thereof) to this battle among the professions. The resultant laws, regulations, and court opinions can improve the quality of patient care, or they

106. Howard Blanchette, *Comparison of Obstetric Outcome of a Primary-Care Access Clinic Staffed by Certified Nurse-Midwives and a Private Practice Group of Obstetricians in the same Community*, 172 *Am. J. Obstetrics & Gynecology* 1864, 1864 (1995).

can unnecessarily restrict access to quality care. The provision of authority over particular services and technologies can substantially increase or reduce the costs of services, which can in turn affect patient access. Further, access to care can also be severely reduced if exclusive power is granted to professionals who are unavailable in a particular geographic region.

Henceforth, patient care ought to be the primary focus of power allocations. Each decision must be made with the best available data that shows how patients would be affected. By deliberating over the potential consequences of the legislative, political, and litigative resolutions according to the three important factors – quality, cost, and access – the medical hierarchy may be modified to achieve its actual purpose: the provision of care to the people who need it. A balance of these factors will bring about the most effective and sustainable way to meet the interests of the patient.

