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Rhode Island Nurse Practitioners: Are They Legally Practicing Medicine Without a License?

Judge Janette A. Bertness*

I. INTRODUCTION

There is an evolving trend in health care to use mid-level practitioners a.k.a. physician extenders, to provide health care services traditionally performed by physicians (MDs).¹ Mid-level practitioners include advanced-practice nurses and physician assistants.² An advanced-practice nurse (APN) is a registered nurse who is also licensed to practice in an advanced role.³ The designation “advanced practice nurse,” includes: certified registered nurse anesthetist (CRNA); clinical nurse specialist (CNS); certified

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1. See CAROLYN BUPPERT, *NURSE PRACTITIONER'S BUSINESS PRACTICE AND LEGAL GUIDE 2* (Jones and Bartlett Publishers, Inc. 2d ed. 2004); MICHELE ROTH-KAUFFMAN, *THE PHYSICIAN ASSISTANT'S BUSINESS PRACTICE AND LEGAL GUIDE 10* (Jones and Bartlett Publishers, Inc. 2006); See, e.g., Sharon Christian et al., *Overview of Nurse Practitioner Scopes of Practice in the United States – Discussion*, U.C.S.F. Center for the Health Professions (2007), available at <http://www.futurehealth.uscf.edu/publications/index.htm>; Roderick Hooker & Linda McCraig, *Use of Physician Assistants and Nurse Practitioners in Primary Care, 1995-1999*, 20 *HEALTHCARE QUARTERLY* 231 (2001). The designation “MD” will refer to all licensed physicians trained in allopathic medicine or osteopathic medicine.

2. 21 C.F.R. § 1300.01(b)(28) (2008).

3. R.I. GEN. LAWS § 5-34-3(1) (2004) (stating “[a]dvanced practice nurse” means the status of qualified individuals who hold an active license as a registered nurse and an active license as a nurse in an advanced role as defined under the provisions of this chapter or chapter 5-34.2”).

nurse mid-wife (CNM); and nurse practitioner (NP).⁴ A physician assistant (PA) is a “health care professional who has graduated from an accredited PA educational program and is authorized by the state to practice medicine under the supervision of a licensed physician.”⁵

In Rhode Island, NPs are legislatively authorized to practice their profession autonomously.⁶ Previously, Rhode Island NPs who qualified for prescriptive privileges were required to prescribe medication according to annually updated guidelines written in collaboration with an MD consultant.⁷ In 2008, the Rhode Island

4. A nurse anesthetist performs a narrow range of services to people receiving anesthesia including preoperative assessment, administering anesthesia and post-anesthesia recovery. A clinical nurse specialist provides specialty nursing care to a narrow patient base. The services may include research, consultation, education, case management and direct patient care. A certified nurse midwife provides direct care to women during pregnancy through delivery and post-partum. They may also provide well gynecologic care. Nurse practitioners provide a wide range of care including primary care involving evaluation, diagnosis, treatment, education, case management and well care. BUPPERT, *supra* note 1, at 3; *see also* R.I. GEN LAWS §§ 5-34-3(3) (2004), 5-34.2-2 (Supp. 2008).

5. ROTH-KAUFFMAN, *supra* note 1, at 1.

6. R.I. GEN. LAWS § 5-34-3(3) (2004) (stating a “[c]ertified registered nurse practitioner’ is an advanced practice nurse utilizing independent knowledge of physical assessment and management of health care and illnesses. The practice includes prescriptive privileges. The practice includes collaboration with other licensed health care professionals including, but not limited to, physicians, pharmacists, podiatrists, dentists and nurses”).

7. *See* R.I. GEN LAWS § 5-34-39 (2004), provides as follows:

(a) Prescriptive privileges for the certified registered nurse practitioner:

(1) Shall be granted under the governance and supervision of the department, board of nurse registration and nurse education; and

(2) Shall include prescription of legend medications and prescription of controlled substances from schedules II, III, IV and V that are established in regulation; and

(3) Must not include controlled substances from Schedule I.

(b) A certified registered nurse practitioner (R.N.P.) as stated in § 5-34-3 is permitted to prescribe in accordance with annually updated guidelines, written in collaboration with the medical director or physician consultant of their individual establishments.

(c) To qualify for prescriptive privileges an applicant must submit on forms provided by the board of nurse registration and nursing education, verified by oath, that the applicant has evidence of completion

legislature eliminated the guideline requirement allowing NPs to prescribe any medication that an MD can prescribe.⁸ Absent this requirement, NPs may provide professional health care services without any MD supervision or collaboration. Effectively, they may practice their profession autonomously in the same manner as an MD.

I will test the hypothesis of whether NPs are “practicing medicine” as legally defined in Rhode Island. I will do this by comparing NPs with PAs and MDs from a medical-legal perspective. I have included PAs in this comparison because they render many of the same services as NPs, and their services are considered practicing medicine under the supervision and control of an MD.⁹ I will discuss differences in education, training, scope of practice, services provided, standard of care, licensing requirements, and public perception. To date the issue of whether independently practicing NPs are practicing medicine has never been addressed. Based on my findings, I will propose legislation to clarify the NP’s role in Rhode Island.

II. DEFINITIONS OF PHYSICIAN, NURSE PRACTITIONER AND PHYSICIAN ASSISTANT

A. What is a Physician?

According *Taber’s Cyclopedic Medical Dictionary*, “physician” is: “A person who has successfully completed the prescribed course of studies in medicine in a medical school officially recognized by the country in which it is located, and who has acquired the requisite qualifications for licensure in the practice of medicine.”¹⁰

of thirty (30) hours of education in pharmacology within the three (3) year period immediately prior to date of application. To maintain prescriptive privileges the certified registered nurse practitioner (R.N.P.) must submit upon request of the board of nurse registration and nursing education evidence of thirty (30) hours continuing education in pharmacology every six (6) years.

8. See R.I. GEN. LAWS § 5-34-39 (Supp. 2008).

9. ROTH-KAUFFMAN, *supra* note 1, at 1.

10. Clarence W. Taber, *TABER’S CYCLOPEDIA MEDICAL DICTIONARY*, 1506 (F.A. Davis Company 17th ed. 1993) [hereinafter *Taber’s*]; *but cf.*, SAIF Corp. v. Johnson, 108 P.3d 662, 666 (2005) (“physician” is anyone licensed to practice a healing art for purposes of workers’ compensation, and that definition

“Physician” is defined by Rhode Island law as “a person with a license to practice allopathic or osteopathic medicine in this state under the provisions of this chapter.”¹¹

B. What is a Nurse Practitioner?

According to the American Academy of Nurse Practitioners:

Nurse Practitioners are licensed independent practitioners who provide primary and/or specialty nursing and medical care in ambulatory, acute and long-term care settings. They are registered nurses with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of primary care, acute and long term care settings. Master’s, post master’s or doctoral preparation is required for entry level practice.¹²

Federal law defines nurse practitioner and physician assis-

does not limit the ability to provide medical treatment to those with a medical degree); *Driver v. Rod & Reel Rest.*, 866 P.2d 512, 513 (1994) (physical therapist is a “physician” entitled to measure claimant’s impairment for purposes of workers’ compensation); *Cook v. Workers’ Comp. Dept.*, 758 P.2d 854, 859, 861 (1988) (NP is a physician under Workers’ Compensation law) (dissent: legislative intent not to make NP equal to physician).

11. R.I. GEN. LAWS § 5-37-1(13) (2004). Rhode Island law does not define the terms “allopathic” or “osteopathic” medicine. According to *Taber’s, supra* note 10, at 72:

“allopathy” is a:

1. System of treating disease by inducing a pathologic reaction that is antagonistic to the disease being treated.
2. A term erroneously used for the regular practice of medicine to differentiate it from homeopathy. *Id.*

“Osteopathy” is defined as:

A system of medicine based upon the theory that the normal body is a vital mechanical organism in which structural and functional states are of equal importance and that the body is able to rectify itself against toxic conditions when it has favorable environmental circumstances and satisfactory nourishment. Therefore, it is the osteopathic physician’s responsibility to remove any internal or external abnormalities of the system. Although using manipulation for the most part to restore balance, osteopaths also rely upon physical, medicinal, and surgical methods. Osteopathy, which was founded by Dr. Andrew Taylor Still (1828-1917), is recognized as a standard method or system of medicine and surgical care. *Id.* at 72.

12. STANDARDS OF PRACTICE FOR NURSE PRACTITIONERS §I (Am. Acad. of Nurse Practitioners 2007).

tant in terms of individual state law as follows: The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this subchapter, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.¹³

According to Rhode Island law a certified registered nurse practitioner' is "an advanced practice nurse utilizing independent knowledge of physical assessment and management of health care and illnesses. The practice includes prescriptive privileges. The practice includes collaboration with other licensed health care professionals including, but not limited to, physicians, pharmacists, podiatrists, dentists and nurses."¹⁴ Nowhere does Rhode Island law define what is meant by "includes collaboration."¹⁵

13. 42 U.S.C.A. § 1395x (aa)(5)(A) (Supp. 2008).

14. R.I. GEN. LAWS § 5-34-3(3) (2004). Rhode Island General Laws § 5-34-3(1) (defining "[a]dvanced practice nurse" as: the status of qualified individuals who hold an active license as a registered nurse and an active license as a nurse in an advanced role as defined under the provisions of this chapter or chapter 5-34.2"). Chapter 5-34.2 pertains to nurse anesthetists. Certified registered nurse practitioners in Rhode Island may use the abbreviation "R.N.P." R.I. GEN. LAWS § 5-34-38 (2004).

15. Federal law defines the term "collaboration" as it pertains to nurse practitioners as follows:

The term "collaboration" means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed. 42 U.S.C.A. § 1395x (aa)(6) (Supp. 2008).

BLACK'S LAW DICTIONARY defines the word "include" as follows:

To confine within, hold as in an inclosure, take in, attain, shut up, contain, inclose, comprise, comprehend, embrace, involve. Term may, according to context, express and enlargement and have the meaning of *and* or *in addition to*, or merely specify a particular thing already included within the general words theretofore used. BLACK'S LAW DICTIONARY 777 (5th ed. 1979) [hereinafter *Black's*].

C. What is a Physician Assistant?

A physician assistant is “a health care professional who has graduated from an accredited PA educational program and is authorized by the state to practice medicine under the supervision of a licensed physician.”¹⁶ According to Rhode Island law, ‘Physician Assistant’ means “a person who is qualified by academic and practical training to provide those certain patient services under the supervision, control, responsibility and direction of a licensed physician.”¹⁷

16. ROTH-KAUFFMAN, *supra* note 1, at 1.

17. R.I. GEN. LAWS § 5-54-2(9) (2004). *See also* R.I. GEN. LAWS § 5-54-2(10) (2004) (defining “supervision” as:

overseeing the activities of and accepting the responsibility for the medical services rendered by the physician assistants. Supervision is continuous, and under the direct control of a licensed physician expert in the field of medicine in which the physician assistants practice. The constant physical presence of the supervising physician or physician designee is not required. It is the responsibility of the supervising physician and the physician assistant to assure an appropriate level of supervision depending on the services being rendered. Each physician or group of physicians or other health care delivery organization excluding licensed hospital or licensed health care facilities controlled and operated by a licensed hospital employing physician assistants must have on file at the primary practice site a copy of a policy in the form of an agreement between the supervising physicians and physician assistants delineating:

- (i) The level of supervision provided by the supervising physician or designee with particular reference to differing levels of supervision depending on the type of patient services provided and requirements for communication between the supervising physician or designee and the physician assistant.
- (ii) A job description for the physician assistant listing patient care responsibilities and procedures to be performed by the physician assistant.
- (iii) A program for quality assurance for physician assistant services including requirements for periodic review of the physician assistant services.
- (iv) Requirements for supervision of physician assistants employed or extended medical staff privileges by licensed hospital or other licensed health care facilities or employed by other health care delivery agencies shall be delineated by the medical staff by laws and/or applicable governing authority of the facility.
- (v) The supervising physician or physician designee must be available for easy communication and referral at all times).

III. HISTORY

A. Regulated Medicine

The United States has regulated medicine since colonial times.¹⁸ Laws initially concerned disease control and nuisance abatement.¹⁹ The states shifted regulatory emphasis from public health to the medical profession following the civil war when a scientific basis developed for understanding disease process.²⁰ Thereafter, states began to distinguish the practice of medicine and prohibit ineffective and dangerous treatments.²¹ States defined the “practice of medicine” by the manner of diagnosis and treatment used by physicians who met state licensure requirements.²² “This effectively delegate[d] the definition of appropriate medical practice to medical schools, residency programs and their private accreditation agencies.”²³

B. The Birth of NPs and PAs

NPs and PAs first developed in the United States in the mid-1960s in response to a shortage of MDs in primary care.²⁴ The purpose was to increase health care for the underserved in urban and rural areas.²⁵ NP education was first developed as a master’s degree program at the University of Colorado in 1965.²⁶ Similarly, the first class of PAs graduated from Duke University Medical

18. Thomas R. McLean, *Crossing the Quality Chasm: Autonomous Physician Extenders Will Necessitate a Shift to Enterprise Liability Coverage for Health Care Delivery*, 12 HEALTH MATRIX 239, 244 (2002).

19. *Id.*

20. *Id.*

21. *Id.* at 245.

22. *Id.*

23. *Id.* (quoting 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 HEALTH L. 201, 211 (1999)).

24. See BUPPERT, *supra* note 1, at 6; ROTH-KAUFFMAN, *supra* note 1, at 1.

25. Susan E. Baker, Note, *The Nurse Practitioner in Malpractice Actions: Standard of Care and Theory of Liability*, 2 HEALTH MATRIX 325, 326 (1992); David E. Mittman, *Physician Assistants in the United States*, 325 BMJ 485, 485 (2002).

26. BUPPERT, *supra* note 1, at 7; Christian, *supra* note 1, at 2-3. (The NP was envisioned as making medical as well as nursing diagnoses. They would treat patients with medical therapeutics including prescriptive medication).

Center in 1965.²⁷ States began regulating the practice of NPs and PAs as they developed.²⁸ Presently all fifty states grant some form of prescriptive privileges to NPs and nearly all states grant similar privileges to PAs.²⁹

IV. PRIMARY CARE

“Primary care” is defined in *Taber’s Cyclopedic Medical Dictionary* as:

“Basic or general health care provided at the person’s first contact with the health care system. Usually this contact is for common illnesses. The primary health care provider assumes ongoing responsibility for health maintenance and therapy for illness, including consultation with specialists.”³⁰

In Rhode Island, the definition of “primary care” as adopted from the National Academy of Sciences’ Institute of Medicine is as follows: “Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”³¹

MDs, NPs and PAs may all render primary care.³² It is estimated that 85 % of NPs and 50% of PAs perform primary care.³³

27. ROTH-KAUFFMAN, *supra* note 1, at 1.

28. BUPPERT, *supra* note 1, at 7.

29. BUPPERT, *supra* note 1, at 183-87; ROTH-KAUFFMAN *supra* note 1, at 315-86; Linda J. Pearson, *The Pearson Report*, 12 AM. J. NURSE PRACTITIONERS 2, at 6, 22-23 (2008) (showing prescriptive privileges in all fifty states).

30. *Taber’s*, *supra* note 10, 1597.

31. INSTITUTE OF MEDICINE, PRIMARY CARE: AMERICAN’S HEALTH IN A NEW ERA 1 (Molla S. Donaldson et al. eds., National Academy Press 1996) *quoted in* BUPPERT, *supra* note 1, at 7-8; *see also* R.I. GEN LAWS §§ 27-68-1(7) (Supp. 2008), 40-8.4-16(7) (2006).

32. *See* R.I. GEN. LAWS §§ 5-37-2, 5-34-3(3), 5-54-8; BUPPERT, *supra* note 1, at 37; ROTH-KAUFFMAN, *supra* note 1, at 2, 4; *but see*, ROTH-KAUFFMAN, *supra* note 1, at 10 (PA supervising physician provides primary care, not PA; PA has a job description, not a scope of practice).

33. Roderick S. Hooker, *Physician Assistants and Nurse Practitioners: The United States Experience*, 185 MED. J. OF AUSTRALIA 4 (2006). As of 2006 there were 110,000 NPs and PAs comprising one sixth of the medical work force.

PA primary care is rendered under the direct “supervision, control, responsibility and direction” of the supervising MD.³⁴ PA services are “delegated” by the supervising MD. Therefore, the supervising MD may be held liable for PA malpractice.³⁵

MDs and NPs may render primary care independently.³⁶ The question is whether the primary care rendered by NPs is the same as the primary care rendered by MDs.³⁷ If so; NPs may be practicing medicine per se. To reach this determination, I will compare the education, training, scope of practice, services provided, and efficacy of patient outcomes between these health care providers.

V. EDUCATION

A. Physician Education

MD education and clinical training is the most comprehensive of any health care provider.³⁸ All MDs complete a college degree including certain pre-requisite course work before attending an accredited medical school.³⁹ Medical school is typically a four year degree.⁴⁰ The first two years are spent in the “preclinical” phase.⁴¹ Students first study the normal structure and function of the human system.⁴² Students take courses in anatomy, physiology, biochemistry, neuroscience and behavioral science.⁴³ Students then focus on “abnormalities of the body’s structure and function, disease, and general therapeutic principles.”⁴⁴ This lat-

34. See *supra* text accompanying note 17.

35. The supervising MD is responsible for all PA rendered medical services. R.I. GEN. LAWS § 5-54-2(10) (2004); see Theories of Liability, *infra* p. 32.

36. See *supra* notes 11, 14 and accompanying text.

37. Patients express a higher degree of satisfaction with NP primary care over MD primary care. Baker, *supra* note 25, at 332.

38. Phylliss Coleman & Ronald A. Shellow, *Extending Physician’s Standard of Care to Non-physician Prescribers: The Rx For Protecting Patients*, 35 IDAHO L. REV. 37, 52 (1998).

39. McLean, *supra* note 18, at 257.

40. See MedicineNet.com, <http://www.medterms.com/script/main/art.asp?articlekey=30954> (last visited Jan. 7, 2009).

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

ter coursework includes microbiology, immunology, pharmacology and pathology.⁴⁵ The second two years of medical school consists of education in a clinical setting including rotations in such areas as internal medicine, pediatrics, psychiatry, surgery, obstetrics/gynecology and family medicine.⁴⁶

Following graduation from medical school, all MD candidates are required to complete a one year supervised internship.⁴⁷ They must also pass a series of national licensing examinations which begin following their second year of medical school and conclude following internship.⁴⁸ It takes approximately nine years to complete this training which qualifies the MD as a general practitioner.⁴⁹ In order for an MD to specialize in a particular field of medical practice, s/he must complete an additional residency program of between two to six years and then take an additional board certification examination six months to two years after completing the residency program.⁵⁰ Some applicants must pass both a written and an oral examination to achieve board certification in a particular field.⁵¹ Therefore, MDs usually have a minimum of seven years of training post college education. In addition, they are required to complete a certain amount of continuing medical education and they must be recertified in their field of practice every ten years.⁵²

B. Nurse Practitioner Education

All NPs are registered nurses (RNs) with additional education.⁵³ Education for RNs varies from completing a two year associate degree in nursing (ADN); a three year hospital administered diploma program; or obtaining a four year Bachelor of Science degree in nursing (BSN).⁵⁴ Regardless of the degree obtained, all nurses who pass a national licensing examination are equally des-

45. *Id.*

46. *Id.*

47. McLean, *supra* note 18, at 257.

48. *Id.* at 257-58.

49. *Id.*

50. *Id.*

51. *Id.* at 258.

52. *Id.* at 258-59.

53. BUPPERT, *supra* note 1, at 5.

54. ROTH-KAUFFMAN, *supra* note 1, at 12.

ignated as registered nurses (RNs).⁵⁵

Nursing is based on a holistic approach to deliver patient focused care.⁵⁶ Nursing education consists of both didactic and clinical components.⁵⁷ The first two years of a typical four year BSN program consist of courses in human anatomy and physiology; microbiology; nutrition; chemistry; human growth and development; and psychology.⁵⁸ The second two years typically focus on acute and chronic disease; female reproductive health; pediatrics; psychiatric health; community health; nursing theory; bioethics; health assessment; pharmacology; research and statistics; pathophysiology; and electives.⁵⁹ Supervised clinical practice generally occurs during the last two years in hospitals, nursing homes and the community.⁶⁰

State qualifications for NPs vary widely, from requiring as little as one additional year of academic training post RN licensure to requiring a master's degree level of education with a clinical component, certification by a national organization, continuing education, and training in pharmacology.⁶¹ NP programs generally include courses in advanced practice nursing philosophy, ad-

55. *Id.*

56. American Nurses Association, Nursing World— About Nursing, <http://www.nursingworld.org/MainMenuCategories/CertificaionandAccreditation/AboutNursing> (last visited Jan. 7, 2009). “What defines nursing and sets it apart from other health care professions, particularly medicine with which it has long been considered part and parcel? It is the nurses’ focus – in theory and practice – on the response of the individual and the family to actual or potential health problems. Nurses are educated to be attuned to the whole person, not just the unique presenting health problem. While a medical diagnosis of an illness may be fairly circumscribed, the human response to the health problem may be much more fluid and variable and may have a great effect on the individual’s ability to overcome the initial medical problem. It is often said that physicians cure, and nurses care. In what some describe as a blend of physiology and psychology, nurses build on their understanding of the disease and illness process to promote the restoration and maintenance of health in their clients.” *Id.*

57. ROTH-KAUFFMAN, *supra* note 1, at 12.

58. American Nurses Association, *supra* note 56; *see, e.g.*, Illinois Wesleyan School of Nursing courses and descriptions, <http://www2.iwu.edu/nursing/curriculum> (last visited Jan. 7, 2009).

59. *See* American Nurses Association, *supra* note 56.

60. *See id.*

61. BUPPERT, *supra* note 1, at 5. Approximately half of the states require NPs to have a master’s degree in nursing. Christian, *supra* note 1, at 1. Forty-two states require NPs to have national certification. *Id.*

vanced health assessment, diagnosis, advanced pathophysiology, advanced pharmacology, primary care and clinical decision making.⁶² NPs may be certified in a variety of specialties including family, pediatric, adult, geriatric, and women's care.⁶³

Presently, all NP applicants seeking initial licensure to practice in Rhode Island must possess a master's degree in nursing from an accredited program and pass a national qualifying examination.⁶⁴ The Board of Nursing may grant prescriptive privileges to NPs who have completed thirty hours of pharmacology education during the three years prior to application.⁶⁵ Once granted,

62. See The College of New Jersey School of Nursing, curriculum for nurse practitioner programs, http://www.tcnj.edu/~nursing/programs/np_curriculum.html; St. Joseph's College family nurse practitioner curriculum, <http://www.sjc.edu/content.cfm/pageid/5679>.

63. BUPPERT, *supra* note 1, at 6.

64. R.I. GEN LAWS § 5-34-35(a) (2004) provides in pertinent part as follows:

(1) The applicant is a registered nurse who has completed an accredited educational program resulting in a master's degree in nursing and/or an approved nurse practitioner course of study. This curriculum must include both a didactic component and supervised clinical experience. Effective January 1, 2004, all applicants for initial licensure must complete an accredited educational program resulting in a master's degree with a major in nursing.

(2) The applicant passed a national qualifying examination recognized by the board of nurse registration and nursing education.

65. R.I. GEN. LAWS § 5-34-39 (2008) provides as follows:

(a) Prescriptive privileges for the certified registered nurse practitioner:

Shall be granted under the governance and supervision of the department, board of nurse registration and nursing education; and

Shall include prescription of legend medications and prescription of controlled substances from schedules II, III, IV and V that are established in regulation; and

Must not include controlled substances from Schedule I.

(b) To qualify for prescriptive privileges an applicant must submit on forms provided by the board of nurse registration and nursing education, verified by oath, that the applicant has evidence of completion of thirty (30) hours of education in pharmacology within the three (3) year period immediately prior to date of application. To maintain prescriptive privileges the certified registered nurse practitioner (R.N.P.) must submit upon request of the board of nurse registration and nursing education evidence of thirty (30) hours continuing education in pharmacology every six (6) years.

the NP can prescribe any controlled substance that an MD may prescribe.⁶⁶

C. Physician Assistant Education

PA education is based on the medical model of primary care and complements MD training.⁶⁷ The majority of students have at least a bachelor's degree and many have several years of prior medical experience.⁶⁸ A typical PA program is two years.⁶⁹ The first year is didactic, including courses such as anatomy, physiology, pathophysiology, pathology, biochemistry, microbiology, pharmacology, physical diagnosis, laboratory science, behavioral medicine, ethics, and clinical medicine.⁷⁰ The second year is devoted to supervised clinical rotations in physician's offices, hospitals and clinics.⁷¹

PA students are "required to demonstrate proficiency in medical knowledge and meet behavioral and clinical objectives."⁷² Accredited PA programs are required to meet educational standards of the Accreditation Review Commission on Education for the Physician Assistant Inc. (ARC-PA).⁷³ Every state requires PAs to pass the Physician Assistant National Certifying Exam (PANCE) in order to be licensed.⁷⁴ PAs maintain certification following graduation by completing one hundred hours of continuing medical education every two years and passing a recertification examination every six years.⁷⁵ There are also several post-graduate programs which offer additional training in such areas as orthopedics, oncology and cardiovascular surgery.⁷⁶

66. *Id.*; see Uniformed Controlled Substances Act, R.I. GEN. LAWS § 21-28-1.01 et seq. (2002 & Supp. 2008).

67. ROTH-KAUFFMAN, *supra* note 1, at 4.

68. *Id.* at 5. ("It is common for emergency medical technicians, nurses and paramedics to apply to PA programs").

69. *Id.* at 4.

70. *Id.*

71. *Id.* at 4-5.

72. *Id.* at 4.

73. *Id.*

74. *Id.* at 9.

75. *Id.* at 5.

76. ROTH-KAUFFMAN, *supra* note 1, at 4.

D. Comparing MD, NP and PA Education

Unquestionably, MDs undergo the most in depth scientific and clinical educational experience of all health care practitioners. Nurse practitioner education and training appears to be significantly less rigorous in terms of time, scientific education and clinical experience. Moreover, state licensing requirements for nurse practitioners appear to be the most variable among the three types of providers. While all MDs and PAs must achieve a particular degree status and pass national certifying examinations, all NPs do not.⁷⁷ Additionally, MDs and PAs are trained under the "medical model," whereas nurse practitioner education and training is based on the "nursing model."⁷⁸ It appears that this may be more of a difference in philosophy of practice rather than a difference in the professional services provided. An argument could be made that the differences between the medical and nursing models of health care delivery are analogous to the differences between the allopathic and osteopathic models of health care delivery. Therefore, it is necessary to review these providers' scopes of practice and services provided.

77. Pearson, *supra* note 29, at 16-17. Since 2004, all applicants for initial licensure as an NP in Rhode Island must have a master's degree in nursing from an accredited program and must pass a national qualifying examination. R.I. GEN. LAWS § 5-34-35 (2004).

78. See *supra* note 56 and accompanying text; the term "medical model" is not clearly defined. See also GORDON MARSHALL, A DICTIONARY OF SOCIOLOGY, Oxford University Press (1998) ("More commonly, the term refers to medicine's ideas and assumptions about the nature of illness, notably its natural scientific framework and its focus on physical causes and physical treatments. As such the term is frequently invoked in the context of ideological and political debates and inter-professional rivalries in which the relevance of this particular set of ideas is called into question. One problem with the term is that it suggests a uniformity of medical ideas about causation and treatment that does not fit the empirical diversity very well, since doctors do not focus exclusively on physical factors, even in relation to physical illness. For this reason some prefer the term 'bio-medical model', since it clearly indicates the focus on the biological, and allows that there are other medical models. An alternative model of health and illness, employed by some doctors but especially favoured in nursing circles for its greater breadth, is a 'bio-psycho-social model' encompassing the biological, psychological, and social aspects.").

VI. SCOPE OF PRACTICE

“Scope of practice” refers to a health care provider’s legally permissible boundaries of practice as defined by statute, regulation and educational requirements.⁷⁹ It is difficult to strictly define a health care provider’s scope of practice because of the evolving and dynamic nature of all professional practices.⁸⁰ Nevertheless, it is important to define the scope of practice in a way that protects the provider’s professional status and comports with the state’s interest in public health and welfare.⁸¹

A. Physician Scope of Practice

Generally, the scope of practice for all physicians is the practice of medicine.⁸² The practice of medicine in Rhode Island includes the practice of allopathic or osteopathic medicine.⁸³ The practice includes prescribing controlled substances from schedules II through V of the Rhode Island Controlled Substances Act.⁸⁴

B. Nurse Practitioner Scope of Practice

NP scope of practice varies by state from requiring MD supervision to autonomous practice.⁸⁵ NPs may prescribe controlled substances in all fifty states to varying degrees.⁸⁶ All NPs who

79. Baker, *supra* note 25, at 338. “The Tenth Amendment to the United States Constitution delegates the function of professional regulation to the states pursuant to their police powers.” See also Mary Beck, *Improving America’s Health Care: Authorizing Independent Prescriptive Privileges for Advanced Practice Nurses*, 29 U.S.F.L. REV. 951, 952 (1994-1995).

80. Beck, *supra* note 79, at 972; see Baker, *supra* note 25, at 339.

81. See McLean, *supra* note 18, at 247-48; Beck, *supra* note 79, at 952. The purpose of these powers is “to protect the health, safety and welfare” of the general public and not the professions themselves. States regulate physicians and nurses through State Practice Acts. *Id.* The acts typically define professional practice and licensure requirements, establish and delegate certain functions to a state regulatory board, and prohibit unauthorized practice of the particular profession. *Id.*

82. Black’s, *supra* note 15, at 1033 (physician defined).

83. R.I. GEN. LAWS § 5-37-1(13) (2006); see *supra* note 11 and accompanying text.

84. R.I. GEN. LAWS §§ 21-28-1.02 (37)(i) (2006), 21-28-3.03 (c) (2006).

85. Christian, *supra* note 1, at 1; see, e.g., BUPPERT, *supra* note 1, at App. 2-A (State-by-State Law Nurse Practitioner Scope of Practice) and App. 2-B (State-by-State Requirement, if any, of Physician Collaboration).

86. NP prescribing varies from an MD delegated act, MD collaboration,

prescribe controlled substances must register with the federal government Drug Enforcement Administration (DEA).⁸⁷ There is little difference between MD and NP scopes of practice where both include independent diagnosis, treatment, prescriptive authority and hospital privileges.⁸⁸

A Rhode Island NP's scope of practice is to use independent knowledge to physically assess and manage health care and illness.⁸⁹ The practice "includes" prescriptive privileges and "collaboration" with other licensed health care professionals.⁹⁰ In order to qualify for prescriptive privileges, the NP must provide evidence to the Board of Nursing that s/he completed certain pharmacology education requirements.⁹¹ The NP may then prescribe from schedules II through V of the Rhode Island Controlled Substances Act in the same manner as an MD. Independent prescriptive authority was enacted in 2008.⁹² Previously, NPs could only prescribe "in accordance with annually updated guidelines, written in collaboration with the medical director or physician consultant of their individual establishments."⁹³

C. Physician Assistant Scope of Practice

The PA's scope of practice is to provide MD supervised services that are legally authorized by the state in which s/he practices.⁹⁴ In Rhode Island, the PA's scope of practice is to provide patient services, within his/her level of education and experience, "under the supervision, control, responsibility and direction of a licensed physician."⁹⁵ PAs may only provide services that are within the supervising MD's field of medical expertise.⁹⁶ They

to independent prescriptive privileges. BUPPERT, *supra* note 1, at 183.

87. BUPPERT, *supra* note 1, at 186; Beck, *supra* note 79, at 983. (NPs have been able to get their own DEA numbers since 1993 whether they prescribe dependently or independently).

88. BUPPERT, *supra* note 1, at 43.

89. See R.I. GEN. LAWS § 5-34-3(3) (2004).

90. *Id.*; see *supra* note 15 and accompanying text for definitions of "collaboration" and "include."

91. R.I. GEN. LAWS § 5-34-39(c) (2004).

92. See R.I. GEN. LAWS § 5-34-39 (Supp. 2008).

93. R.I. GEN. LAWS § 5-34-39(b) (2004).

94. ROTH-KAUFFMAN, *supra* note 1, at 29-30.

95. R.I. GEN. LAWS §§ 5-54-2(9) (2004), 5-54-8(b) (Supp. 2008).

96. R.I. GEN. LAWS § 5-54-2(10) (2004).

may prescribe controlled substances and medical devices as delegated by the supervising MD. At least one commentator argues that PAs merely have a “job description” and not a “scope of practice” because they do not practice independently.⁹⁷

D. Comparing MD, NP and PA Scopes of Practice in Rhode Island

The most significant difference between MD, NP and PA scopes of practice in Rhode Island is that MDs and NPs may practice “autonomously,” whereas a PA always practices under MD supervision and control. What differentiates MD and NP scopes of practice appears to be differences in their professional licensing requirements which are based on their education and training.⁹⁸ Accordingly, MD and NP differences in education and training define different scopes of practice.

VII. PROFESSIONAL SERVICES

Professional services are services rendered by a member of a profession within the purview of that profession.⁹⁹ The term “professional services” is defined in the Rhode Island General Laws Professional Service Corporations chapter as “personal services by a person authorized to practice” in a particular profession.¹⁰⁰ MDs, NPs, and PAs are all included as persons who render professional services.¹⁰¹ This definition of “professional services,” how-

97. BUPPERT, *supra* note 1, at 10.

98. See R.I. GEN. LAWS §§ 5-34-2, 5-34-3, 5-34-35, 5-34-36, 5-34-39, 5-37-1, 5-37-2 (2004).

99. See <http://lawdigest.uslegal.com/corporations/attorneys/4634/> (last visited Jan. 7, 2009).

100. R.I. GEN. LAWS § 7-5.1-2 (1999 & Supp. 2008), which provides in pertinent part as follows:

“As used in this chapter:

(1) ‘Professional services’ means the rendering of personal services by a person authorized to practice as one of the following professions as defined:

(i) Physicians;

(xi) Registered nurses;

(xvii) Physician assistants.”

101. *Id.*

ever, is specific to the Professional Service Corporations chapter.¹⁰² In *Vigue v. John E. Fogarty Memorial Hosp.*, the Rhode Island Supreme Court specifically refused to extend this definition of professional services to malpractice actions brought against hospitals.¹⁰³ The term “professional services” is used, but not otherwise defined elsewhere in the Rhode Island General Laws.¹⁰⁴

A. MD, NP and PA Professional Services

The descriptions of MD, NP and PA primary care professional services sound very much alike. The U.S. Department of Labor, Bureau of Labor Statistics states that MDs:

“diagnose illnesses and prescribe and administer treatment for people suffering from an injury or disease. Physicians examine patients, obtain medical histories, and order, perform and interpret diagnostic tests. They counsel patients on diet, hygiene, and preventive health care.”¹⁰⁵

NP primary care services include diagnosing and treating

102. *Id.*

103. 481 A.2d 1, 5 (R.I. 1984). In *Vigue*, the Rhode Island Supreme Court addressed the issue of whether a hospital renders professional services and is therefore subject to the two year statute of limitations for professional malpractice rather than the three year statute for simple negligence. *Id.* at 2-3. A divided Court recognized an inconsistency in two sections of the Rhode Island General Laws. *Id.* at 4. The definition of “malpractice” pursuant to title 5, section 37.1-1(f) of the Rhode Island General Laws, included any tort based on “professional services” rendered by a “hospital,” but title 7, section 5.1-2, did not recognize “hospital” as a “person” authorized to practice professional services. *Id.* at 3.

The majority reasoned that title 7, section 5.1-2 of the Rhode Island General Laws related to “individuals” and not to “health-service organizations” subject to the definition of malpractice pursuant to title 5, section 37-1. *Id.* at 4. The Court explained that to accept the proposition that only individuals can render professional services would nullify the term “hospital” under the statutory definition of malpractice. *Id.* The Court had previously held that inconsistent statutory provisions which are in *pari materia* “must be given meaning and effect and all made operative if it be reasonably possible***.” *Id.* (quoting *Nascimento v. Phillips Petroleum Co.*, 346 A.2d 657, 659 (1975)). Moreover, the “professional services” definition in § 7-5.1-2, applied only to chapter 5.1 by its express terms. *Id.* at 5. The Court held that the two year medical malpractice statute of limitations applied. *Id.*

104. *See, e.g.*, R.I. GEN. LAWS §§ 5-37-1, 5-37-5.1, 5-37-9, 5-54-2, 5-54-23 (2004).

105. U.S. DEPT. LAB., BUREAU LAB. STATISTICS, *Occupational Outlook Handbook*, <http://www.bls.gov/oco/ocos074.htm> (last visited Jan. 7, 2009).

health problems.¹⁰⁶ They do this by obtaining medical histories; ordering and interpreting diagnostic tests and x-rays; prescribing medication and other treatments; and providing education and case management.¹⁰⁷

PAs practice medicine under the supervision of an MD.¹⁰⁸ They obtain patient histories; perform comprehensive examinations; diagnosis; order and interpret diagnostic tests and x-rays; prescribe medication and other treatments; and provide education and treatment plans.¹⁰⁹

From a legal viewpoint, PA services differ from MD and NP services because PA services are delegated acts.¹¹⁰ Only MDs and NPs may use independent judgment when rendering professional services.¹¹¹ Moreover, the scope of professional services rendered by each of these providers is limited by their education and training.

MD supporters contend that because MDs have significantly more education and training, it is naive to conclude that primary care rendered by the average MD is the same as primary care rendered by the average NP.¹¹² Furthermore, they argue that lack of a comprehensive medical background will cause NPs to misdiagnose atypical cases.¹¹³ They suggest that the non-physician health care provider does not have enough knowledge to recognize what s/he does not know.¹¹⁴ These arguments, however, concern the quality of care and not the care itself.

Efficacy outcome studies demonstrate that NP primary care treatment is equal to or better than treatment provided MDs.¹¹⁵

106. BUPPERT, *supra* note 1, at 3.

107. *Id.*

108. ROTH-KAUFFMAN, *supra* note 1, at 2.

109. *Id.* at 2-3.

110. *Id.* at 2.

111. Pearson, *supra* note 29, at 18, 21. In thirteen states NPs need no MD involvement in diagnosis, treatment or prescribing. *Id.*

112. Mc Lean, *supra* note 18, at 260. If MDs and NPs provided the same quality of care there would be no reason to provide health care education past the master's degree level and no incentive to invest additional time and money in obtaining a doctorate level degree. *Id.*

113. Coleman, *supra* note 38, at 50; *see also* BUPPERT, *supra* note 1, at 238-40 (cases where NP sued for missed diagnosis).

114. Coleman, *supra* note 38, at 50.

115. Sharon A. Brown & Deanna E. Grimes, *A Meta-analysis of Nurse Practitioners and Nurse Midwives in Primary Care*, 44 NURSING RES. 332, 337

Studies also demonstrate that NPs prescribe controlled substances safely and reliably.¹¹⁶ They conclude that NPs can provide fifty to ninety percent of all primary care.¹¹⁷

Sources contend that NP services are indistinguishable from MD services in a primary care setting.¹¹⁸ The only difference in care is the model of care delivery.¹¹⁹ Columbia Advanced Practice Nurse Associates (CAPNA), a New York based independent NP practice, advertises that they “can do anything that a primary care physician can do.”¹²⁰ NPs argue that they render many of the same services as their MD counterparts and, therefore, should be reimbursed for those services at the same rate.¹²¹

Courts have acknowledged that NPs and MDs perform overlapping functions.¹²² The medical services that MDs and NPs

(1995); Richard A. Cooper, *Quality Among a Diversity of Health Care Providers*, 185 MED. J. AUSTL. 2, 3 (2006); Hooker, *supra* note 33, at 5; Roderick Hooker, *A Cost Analysis of Physician Assistants in Primary Care*, 11 JAAPA 39 (2002); Sue Horrocks, Elizabeth Anderson & Chris Salisbury, *Systemic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors*, 324 BRIT. MED. J. 819, 821 (2002); Mary O. Munding et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioner or Physicians*, 283 JAMA 59, 68 (2000); Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417, 431 (1992); *cf.* Hooker, *supra* note 33, at 5 (PAs can provide eighty percent or more of services provided by MDs at same level of quality).

116. Beck, *supra* note 79, at 957.

117. Baker, *supra* note 25, at 331; *see* Beck, *supra* note 79, at 957.

118. Baker, *supra* note 25, at 328.

119. *Id.* at 341.

120. Lyndia Flanagan, *Nurse Practitioners: Growing Competition for Family Physicians?*, 5 FAM. PRAC. MGMT. 34, 34 (1998). CAPNA NPs have hospital admitting privileges, are listed as providers in managed care organizations, are reimbursed at the same rate as physicians and are in direct competition with physicians. *Id.* at 35. NPs advocate that they should be considered the final authority on primary care and in other areas where they have specialized knowledge, education and expertise. BUPPERT, *supra* note 1, at 476-77.

121. *See National Association of Pediatric Nurse Practitioners Position Statement on Reimbursement for Nurse Practitioner Services*, 18 J. OF PEDIATRIC HEALTH CARE A27, A27 (2004).

122. *See Tucker v. Talley*, 600 S.E.2d 778, 782 (Ga. Ct. App. 2004) (NP cannot testify to physician standard of care where actions do not overlap); *Planned Parenthood of Northwest Indiana, Inc. v. Vines*, 543 N.E.2d 654, 660 (Ind. Ct. App. 1989) (physician can testify to NP standard of care for overlapping procedure where standard of care was the same); *cf. In re Stacy K. Boone*, 223 S.W.3d 398, 407 (Tex. App. 2006) (physician can testify to PA standard of care when performing overlapping functions and held to same

render in co-extensive areas of practice are essentially the same.¹²³ In those cases, NPs and MDs are held to the same standard of care.¹²⁴ The area of professional overlap is called the “interprofessional intersection.”¹²⁵ Therefore, it would not be unreasonable for the court to find that NPs are practicing medicine when they are performing overlapping functions independently.

B. MD, NP and PA Services in Rhode Island

1. Licensing and Regulation

The Board of Medical Licensure and Discipline regulates the practice of medicine in Rhode Island.¹²⁶ To obtain a license to practice allopathic or osteopathic medicine, an MD must present evidence to the board that s/he has graduated from a qualified medical school, completed post graduate training requirements and passed any examination that the board requires.¹²⁷ All li-

standard of care).

123. Baker, *supra* note 25, at 341.

124. Buppert, *supra* note 1, at 237.

125. Baker, *supra* note 25, at 341.

126. See generally R.I. GEN. LAWS §§ 5-37-1 - 32 (2004).

127. R.I. GEN. LAWS § 5-37-2 (2008 Supp.) provides in pertinent part as follows:

“(a) Authority to practice allopathic or osteopathic medicine under this chapter shall be by a license issued by the director of the department of health to any reputable physician who intends to practice allopathic or osteopathic medicine in this state, and who meets the requirements for licensure established in this chapter and regulations established by the board or by the director. Applicants for licensure shall present satisfactory evidence of graduation from a medical school or school of osteopathic medicine approved by the board and in good standing, shall meet post graduate training requirements and any other requirements that the board or director establishes by regulation, and shall pass in a satisfactory manner any examination that the board may require [...]

(2) A license to practice allopathic medicine shall be issued to persons who have graduated from a school of medicine, possess a degree of doctor of medicine (or meet the requirements of subsection (b) of this section), and meet the requirements for licensure.

(3) A license to practice osteopathic medicine shall be issued to persons who have graduated from a school of osteopathic medicine and possess a degree of doctor of osteopathy and otherwise meet the requirements for licensure. A license to practice osteo-

censed MDs must register biannually with the board.¹²⁸ They must also earn a minimum of forty hours of AMA category 1/AOA category 1a continuing medical education hours every two years.¹²⁹

The Board of Nurse Registration and Nursing Education regulates the practice of nursing in Rhode Island.¹³⁰ In order to be licensed as a certified registered nurse practitioner (R.N.P.), the applicant must be licensed (in Rhode Island) as an R.N., complete a master's degree in nursing from an accredited educational program and pass a national qualifying examination.¹³¹ R.N.P.s must renew their licenses yearly and complete ten hours of continuing nursing education every two years.¹³² They must also complete additional training to qualify for prescriptive privileges.¹³³

The Board of Licensure of Physician Assistants regulates PA practice in Rhode Island.¹³⁴ PAs licensed in Rhode Island must be of "good moral character," have graduated from an approved PA

pathic medicine shall confer upon the holder the right to practice osteopathic medicine in all its branches as taught and practiced in accredited colleges of osteopathic medicine. The holder of that license shall be subject to the same duties and liabilities and entitled to the same rights and privileges, which may be imposed by law or governmental regulation, upon physicians of any school of medicine."

The board requires the applicant to be of "good moral character" and to have completed two years of post graduate training. R.I. Dep't of Health, *Rules and Regulations for the Licensure and Discipline of Physicians*, Rule 3.1.1 (October 2007), available at <http://www2.sec.state.ri.us/dar/regdocs/released/pdf/BMLD/4906.pdf>.

128. R.I. GEN. LAWS § 5-37-10 (2008 Supp.).

129. *Rules and Regulations for the Licensure and Discipline of Physicians*, *supra* note 127, Rule 6.1.

130. See generally R.I. GEN. LAWS §§ 5-34-1 to -35 (2004).

131. R.I. GEN. LAWS § 5-34-35; R.I. Dep't of Health, *Rules and Regulations for the Licensing of Nurses and the Standards for the Approval of Basic Nursing Education Programs*, 14-140-022-4 R.I. CODE R. §3.2 (2008). The board also requires applicants to be of "good moral character." *Id.*; see also Nurse Practitioner Education, *supra* p. 10.

132. See R.I. Dep't of Health, *Rules and Regulations for the Licensing of Nurses and the Standards for the Approval of Basic Nursing Education Programs*, 14-140-022-7 R.I. CODE R. §§ 6.0, 8.0.

133. See Nurse Practitioner Education, *supra* p. 10. NPs with prescriptive privileges must complete thirty hours of continuing education in pharmacology every six years. R.I. GEN. LAWS §5-34-39(c) (2004).

134. See R.I. GEN. LAWS §5-54-1 (1956).

training program and have completed a national certifying examination.¹³⁵ PAs must renew their licenses biannually and must complete ten hours of approved medical education annually.¹³⁶

2. Comparing MD, NP and PA Services in Rhode Island

Primary care MDs, NPs and PAs render many of the same services in Rhode Island. There appear to be two main differences between the services rendered by MDs, NPs and PAs. One difference appears to be a matter of semantics: how the services are described versus what service is actually performed. The other difference is whether the services are rendered independently, in collaboration or under supervision and control of a licensed MD.

In Rhode Island, MDs practice medicine. R.N.P.s “utiliz[e] independent knowledge of physical assessment and management of health care and illnesses.”¹³⁷ PAs perform MD delegated health care services consistent with their expertise and that of their supervising physician.¹³⁸ While the descriptions do not

135. R.I. GEN. LAWS § 5-54-9 (Supp. 2008), provides in pertinent part as follows:

“The board shall recommend to the director for licensure as a physician assistant an applicant who:

- (1) Is of good character and reputation;
- (2) Graduated from a physician assistant training program certified by the AMA’s Committee on Allied Health, Education, and Accreditation, its successor, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or its successor.
- (3) Passed a certifying examination approved by the National Commission on Certification of Physician Assistants or any other national certifying exam approved by the board.

136. R.I. GEN. LAWS §§ 5-54-11, 5-54-12.1 (2004).

137. R.I. GEN. LAWS § 5-34-3(3) (2004).

138. R.I. GEN. LAWS § 5-54-8 (Supp. 2008), provides in pertinent part as follows:

“(a) Physician assistants shall practice with physician supervision and shall be considered the agents of their supervising physicians in the performance of all practice-related activities. Whenever any provision of general or public law, or regulation, requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit or endorsement by a physician assistant; provided, however, that nothing in this section shall be construed to expand the scope of practice of physician assistants. Physician assistants may perform those duties and responsibilities consistent with

clearly explain the differences between the services performed, they certainly allow for overlap in functions. Additional evidence that NPs and PAs perform overlapping services with MDs is the fact that they bill insurance companies for their services using the same billing codes as MDs when performing the same services.¹³⁹ Medicare reimburses NPs and PAs at the rate of 85% of what they pay MDs for the same services.¹⁴⁰ When the NP or PA is employed by an MD, however, they may be reimbursed at 100% of the MD charge if they can show that the services were “incident to

the limitations of this section, including prescribing of drugs and medical devices, which are delegated by their supervising physician(s). Physician assistants may request, receive, sign for and distribute professional samples of drugs and medical devices to patients only within the limitations of this section. Notwithstanding any other provisions of law, a physician assistant may perform health care services when those services are rendered under the supervision of a licensed physician.

(b) Physician assistants, depending upon their level of professional training and experience, as determined by a supervising physician, may perform health care services consistent with their expertise and that of the supervising physician, who is a licensed physician in solo practice, in group practice, or in health care facilities.

(c) Physician assistants may write prescriptions and medical orders to the extent provided in this paragraph. When employed by or extended medical staff privileges by a licensed hospital or other licensed health care facility a physician assistant may write medical orders for inpatients as delineated by the medical staff bylaws of the facility as well as its credentialing process and applicable governing authority. Physician assistants employed directly by physicians, health maintenance organizations or other health care delivery organizations may prescribe legend medications including schedule II, III, IV and V medications under chapter 28 of title 21 of the Rhode Island Uniform Controlled Substances Act, medical therapies, medical devices and medical diagnostics according to guidelines established by the employing physician, health maintenance organization or other health care delivery organization.

(d) When supervised by a physician licensed under chapter 29 of this title, the service rendered by the physician assistant shall be limited to the foot. The “foot” is defined as the pedal extremity of the human body and its articulations, and includes the tendons and muscles of the lower leg only as they are involved in conditions of the foot.”

139. . See e.g. BLUE CROSS BLUE SHIELD OF RHODE ISLAND, MEDICAL COVERAGE POLICIES: MID-LEVEL PRACTITIONER (2008), https://www.bcbsri.com/BCBSRIWeb/plansandservices/services/medical_policies/MidLevelPractitioner.jsp.

140. BUPPERT, *supra* note 1, at 270; ROTH-KAUFFMAN, *supra* note 1, at 510.

a physician's professional services."¹⁴¹

The main factor that distinguishes PA services from MD and NP services is that PAs always perform under the supervision and control of an MD. PA services are viewed as MD delegated acts. For this reason, one can argue that it is the MD and not the PA who is practicing medicine.

NP practice involves using independent knowledge in rendering services. NPs use their knowledge of physical assessment to manage health care and illness. This description of R.N.P. practice is so broad that their ability to independently diagnose and treat patients is limited only by the scope of their knowledge. Although the definition of R.N.P. "includes collaboration" with other licensed health care professionals, collaboration is not "required."¹⁴² The plain and ordinary interpretation of this language is that NPs are "authorized" to collaborate with other health care professionals, but collaboration is not "mandated." Thus, it appears that R.N.P.s may provide the same services as MDs if those services are within the scope of their education, training and knowledge. Because the average NP's education, training and knowledge is generally less than that of the average MD, their scope of practice is more limited than the average MD's scope of practice. This does not mean that NPs are not practicing medicine, however, it merely goes to the range of their practice. Similarly, MDs with board certification in a particular specialty perform services that a general practitioner cannot.

VIII. STANDARD OF CARE

A. Negligence

In any negligence action, including medical malpractice, the plaintiff has the burden to establish that the defendant had a duty to act or to refrain from acting; the defendant breached that duty; the plaintiff sustained an injury; and the breach of duty caused the plaintiff's injury.¹⁴³The defendant is held to a "standard of

141. BUPPERT, *supra* note 1, at 271. "[I]ncident to" services are rendered under an MD's "direct personal supervision." *Id.* See also ROTH-KAUFFMAN, *supra* note 1, at 513-14.

142. See What is a Nurse Practitioner?, *supra* p. 3.

143. Perry v. Alessi, 890 A.2d 463, 467 (R.I. 2006); see generally, Baker,

care” which is “that degree of care which a reasonably prudent person should exercise under the same or similar circumstances.”¹⁴⁴ The plaintiff must establish the standard of care and prove that the defendant breached that standard by a preponderance of the evidence.¹⁴⁵

B. Malpractice

In medical malpractice actions the traditional physician standard of care is the “average degree of skill, care, and diligence exercised by members of the same profession, practicing in the same or a similar locality, in light of the present state of medical and surgical science.”¹⁴⁶ Many jurisdictions have now abandoned the so called “similar locality” rule in favor of a national standard of care.¹⁴⁷ Rhode Island subscribes to the national standard.¹⁴⁸

C. Rhode Island Standard of Care

Presently, the standard of care for a Rhode Island MD is “to use the degree of care and skill that is expected of a reasonably competent practitioner in the same class to which he or she belongs, acting in the same or similar circumstances.”¹⁴⁹

Rhode Island applies a comparable standard of care to non-physician health care professionals: “to establish the degree of ‘care, skill and diligence’ used by similarly situated health care providers in the same general line of practice.”¹⁵⁰ Expert testi-

supra note 23, at 343 (malpractice action is the same as a negligence action plus a standard of care beyond a reasonable person standard).

144. *Black's*, at 1260.

145. *Riley v. Stone*, 900 A.2d 1087, 1095 (R.I. 2006).

146. *Gillette v. Tucker*, 65 N.E. 865, 865 (1902).

147. *Sheeley v. Memorial Hosp.*, 710 A.2d 161, 166 (R.I. 1998).

148. *Id.* at 167.

149. *Id.* In Rhode Island, medical malpractice is “any tort, or breach of contract based on health care or professional services rendered, or which should have been rendered, by a physician, dentist, hospital, clinic, health maintenance organization or professional service corporation providing health care services and organized under chapter 5.1 of title 7, to a patient or the rendering of medically unnecessary services except at the informed request of the patient.” R. I. GEN. LAWS § 5-37-1(8) (2004).

150. *Boccasile v. Cajun Music Ltd.*, 694 A.2d 686, 690 (R.I. 1997) (quoting *Leonard v. Providence Hosp.*, 590 So. 2d 906, 908 (Ala. 1991) (standard of care applied to nurse)); see also *Fraijo v. Hartland Hosp.*, 160 Cal. Rptr. 246 (1979) (RN held to RN standard of care); *Hiatt v. Groce*, 523 P.2d 320 (Kan.

mony is required to establish the standard of care and to prove a deviation from it.¹⁵¹ The expert's opinions must rise to the level of a reasonable degree of medical certainty.¹⁵² This means that the testimony must "express some degree of positiveness or probability."¹⁵³

Admission of expert testimony is generally within the sound discretion of the trial judge.¹⁵⁴ The Court will not disturb the trial judge's determination absent clear error or abuse of discretion.¹⁵⁵ In 1986, the Rhode Island legislature enacted legislation concerning expert witnesses in malpractice cases, "purporting to curtail" this discretion.¹⁵⁶ Rhode Island General Laws § 9-19-41 provides as follows: "In any legal action based upon a cause of action arising on or after January 1, 1987, for personal injury or wrongful death filed against a licensed physician, hospital, clinic, health maintenance organization, professional service corporation providing health care services, dentists, or dental hygienist based on professional negligence, only those persons who by knowledge, skill, experience, training, or education qualify as experts in the field of the alleged malpractice shall be permitted to give expert testimony as to the alleged malpractice."¹⁵⁷

The Court noted that § 9-19-41 does not require the expert to practice the same specialty as the defendant in order to testify about the proper standard of care.¹⁵⁸ In determining who is qualified to testify regarding the proper standard of care in a malprac-

1974) (NP standard of care is established by other NPs in the same or similar communities under like circumstances); *Whitney v. Day*, 300 N.W.2d 380 (Mich. 1981) (nurse anesthetist standard of care is the same as that of other nurse anesthetists practicing in the same community); *Paris v. Kreitz*, 331 S.E.2d 234 (N.C. 1985) (PA not held to MD standard of care; health care provider standard of care based on standard for members of same profession with similar training and experience in the same or similar community); *Gaines v. Comanche County Med. Hosp.*, 143 P.3d 203 (Okla. 2006) (RN can testify to standard of care of RN for prevention, cause and treatment of bedsores).

151. *Id.*

152. *Riley*, 900 A.2d at 1092.

153. *Id.*

154. *Sheeley*, 710 A.2d at 164.

155. *Id.*

156. *Debar v. Women and Infants Hosp.*, 762 A.2d 1182, 1186 (R.I. 2000).

157. R.I. GEN. LAWS § 9-19-41 (1997).

158. 762 A.2d at 1186.

tice action, the Court stated in *Sheeley v. Rhode Island Hospital*, that: "Any doctor with knowledge of or familiarity with the procedure, acquired through experience, observation, association, or education, is competent to testify concerning the requisite standard of care and whether the care in any given case deviated from that standard."¹⁵⁹

Accordingly, the *Sheeley* Court held that a board certified obstetrician/gynecologist was qualified to testify as an expert regarding the appropriate standard of care of a second-year family practice resident who performed an episiotomy on a woman during childbirth.¹⁶⁰ The Court noted that the standard of care in performing the procedure at issue had remained constant for over thirty years.¹⁶¹

The Court issued the following decisions which are consistent with *Sheeley*. In *Buja v. Morningstar*, the Court allowed an obstetrician to testify in a malpractice action against a family practitioner whose patient gave birth to an infant with severe birth defects cause by oxygen deprivation during the birthing process.¹⁶² The Court held in *Marshall v. Medical Associates of Rhode Island* that a pediatric and family physician could testify about the standard of care in treating an animal wound bite in a malpractice action against an emergency room doctor and internist.¹⁶³ In *Debar v. Women and Infants Hospital*, the Court held that the trial court erred in excluding a pediatric neurologist's testimony about obstetrical data in an action against a hospital and several of its obstetric/gynecology physicians.¹⁶⁴

The Court relied on Rule 702 of the Rhode Island Rules of Evidence in *Gallucci v. Humbyrd* in determining that a board certified orthopedic surgeon was qualified to give an opinion regarding rehabilitative therapy performed by a physical therapist.¹⁶⁵ Rule 702 supports the notion that an expert does not need the exact same credentials as a malpractice defendant in order to proffer

159. 710 A.2d at 166.

160. *Id.* at 167. An episiotomy is a procedure where the mother's perineum is cut during childbirth to prevent tearing. *Id.* at 163.

161. *Id.* at 167.

162. 688 A.2d 817, 818-19 (R.I. 1997).

163. *Marshall v. Med. Assoc. of R.I., Inc.*, 677 A.2d 425, 426-27 (R.I. 1996).

164. 762 A.2d 1182, 1189 (R.I. 2000)

165. 709 A.2d 1059, 1064-65 (R.I. 1998).

opinion testimony.¹⁶⁶ Rule 702 provides as follows:

“If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of fact or opinion.”

In addition to allowing expert testimony from witnesses who do not have the same credentials as the defendant, *Sheeley* acknowledged that “the *focus in any medical malpractice case should be the procedure performed* and the question of whether it was executed in conformity with the recognized standard of care, the primary concern being whether the treatment was administered in a reasonable manner.” (emphasis added)¹⁶⁷

Consistent with focusing on the procedure performed, in *Vigue v. John E. Fogarty Memorial Hospital*, the Court stated that it is the service itself and not the title of the person performing the service which determines whether professional services were rendered.¹⁶⁸ Thus, it appears that where different professionals render the same professional services, the Court may be inclined to hold them to the same standard of care regardless of their titles.

D. Foreign Jurisdictions' Standard of Care

Foreign jurisdictions have ruled that an expert's knowledge rather than title determine whether s/he can testify in a medical malpractice case.¹⁶⁹ Some courts have allowed MDs to testify regarding non-physician providers' standard of care.¹⁷⁰ Courts have

166. 762 A.2d at 1186.

167. 710 A.2d at 166.

168. 481 A.2d 1, 3 (R.I. 1984); *see supra* note 103 and accompanying text.

169. *See* *Marshall v. Hartford Hosp.*, 783 A.2d 1085, 1097 (Conn. App. Ct. 2001) (witness' knowledge rather than title determine whether s/he can testify as expert in medical malpractice action); *Staccato v. Valley Hosp.*, 170 P.3d 503, 507-08 (Nev. 2007) (medical expert does not need same credentials as care provider to testify to standard of care for procedure or treatment where witness' experience, education and training establish expertise to perform procedure or treatment); *Creasey v. Hogan*, 637 P.2d 114, 120 (Or. 1981) (where principles, techniques and methods of practice are the same, practitioner from one discipline may testify in case against practitioner from another discipline).

170. *See* *Cooper v. Eagle River Memorial Hosp., Inc.*, 270 F.3d 456, 463

also allowed non-physician providers to testify against MDs and other non-physician providers.¹⁷¹ Finally, courts allow health

(7th Cir. 2001) (physician can testify to NP standard of care); *Dukes v. Georgia*, 428 F. Supp.2d 1298, 1311-13 (N.D. Ga. 2006) (physician who has taught or supervised other health care professionals can testify to their standard of care in malpractice action); *Planned Parenthood of Northwest Indiana, Inc. v. Vines*, 543 N.E.2d 654, 660 (Ind. Ct. App. 1989) (physician can testify to NP standard of care for overlapping procedure where standard of care was the same); *Creasey*, 637 P.2d at 120 (physician could testify to standard of care of podiatrist); *Montgomery v. S. Philadelphia Med. Group, Inc.*, 656 A.2d 1385, 1389 (Pa. 1995) (physician can testify to standard of care in treating breast cancer where claimant treated with PA working for PCP); *In re Stacy K. Boone*, 223 S.W.3d 398, 407 (Tex. App. 2006) (physician can testify to PA standard of care when performing overlapping functions and held to same standard of care); *Parker v. Haller*, 751 P.2d 372, 376 (Wyo. 1988) (physician can testify to PA standard of care); *see also* *McElhaney v. Harper-Hutzel Hosp.*, 711 N.W.2d 795, 799-800 (Mich. Ct. App. 2006) (physician opinion sufficient for affidavit of merit against midwife, but not sufficient at trial); *cf. Dukes*, 428 F. Supp. at 1311-13 (physician who has taught or supervised other health care professionals can testify to their standard of care in malpractice action pursuant to O.C.G.A § 24-9-67); *but see* *Simonson v. Keppard*, 225 S.W.3d 868, 874-75, 889 (Tex. App. 2007) (NP held to NP standard of care; physician cannot testify to NP standard of care unless familiar with it, but *see* O'Neill, J., dissenting, arguing that NP and physician should be held to same standard of care when performing a "medical act" of diagnosing or treating a condition).

171. *See* *Nowak v. High*, 433 S.E.2d 602, 603-05 (Ga. Ct. App. 1993) (RN could testify to standard of care of doctor to give injection); *Harris v. Miller*, 438 S.E.2d 731, 742 (N.C. 1994) (trial court erred in failing to allow CRNA to testify that surgeon had negligently supervised CRNA who assisted in surgery where prospective witness was a CRNA for 15 years and was qualified to discuss the level of supervision surgeons should be giving to a CRNA in an emergency situation); *Tabatha N.S. v. Zimmerman*, 2008 Ohio 1639, 23-31 (Ohio Ct. App. 2008) (NP competent expert to testify about standard of care of obstetrical nurses in respondeat superior action against hospital); *see also* *Sturgis Bank & Trust Co. v. Hillsdale Cmty. Health Ctr.*, 708 N.W.2d 453, 456 (Mich. Ct. App. 2005) (NP affidavit of merit sufficient in medical malpractice case against hospital and staff, but may not be used to prove proximate cause at trial); *but cf. Tucker v. Talley*, 600 S.E.2d 778, 782 (Ga. Ct. App. 2004) (NP cannot testify to physician standard of care where actions do not overlap); *contra* *Rudy v. Meshorer*, 706 P.2d 1234, 1237 (Ariz. Ct. App. 1985) (psychiatric RPN could not testify regarding psychiatrist negligence in failing to determine that patient was suicidal); *Nead v. Brown County Gen. Hosp.*, 2007-Ohio-2443, 42-56 (Ohio Ct. App. 2007) (only physician can testify as expert against physician in medical malpractice case, but they may be different specialties); *Bradford v. Alexander*, 886 S.W.2d 394, 397 (Tex. App. 1994) (PA cannot testify to physician standard of care); *Boice v. Marble*, 982 P.2d 565, 571 (Utah 1999) (APRN could not testify in medical malpractice case against psychiatrist to standard of care of post-operative care of spinal

care professionals from different disciplines to testify against each other regarding overlapping functions.¹⁷² In all cases, counsel must lay foundation to establish that the expert witness knows what the appropriate standard of care is for the defendant-health care professional.¹⁷³

Jurisdictions vary on whether to hold non-physician health care providers to the same standard of care as an MD where overlapping services are provided.¹⁷⁴ In Louisiana, an RN may be held to the same standard of care and liability as an MD when performing medical services.¹⁷⁵ The Texas Court of Appeals, allowed an MD to testify that the standard of care for post-operative anti-coagulation therapy following hernia surgery, is the same for a PA and an MD.¹⁷⁶

In *Simonson v. Keppard*, a malpractice action against an NP who failed to diagnose an intracranial hemorrhage, however, the Texas Court of Appeals, in a majority opinion, refused to allow an MD to testify regarding standard of care where there was no testimony that the expert had knowledge of the NP standard of care.¹⁷⁷ The dissent argued that by allowing NPs to perform medical diagnoses and treatment under proper delegation of a supervising MD, the Texas Medical Practice Act effectively incorporated the MD standard of care.¹⁷⁸

In *Fein v. Permanente Medical Group*, the Supreme Court of California held that a trial court erred in instructing a jury that

injury patients, where APRN failed to provide foundation that the standard of care was the same for a rehabilitation nurse or physiatrist).

172. See *Nowak*, 433 S.E.2d at 604-05; *Planned Parenthood v. Vines*, 543 N.E.2d at 660; *Hypolite v. Columbia Dauterive Hosp.*, 968 So.2d 239, 243 (La. Ct. App. 2007) (nurses performing medical services are subject to the same standard of care and liability as MD); *Staccato*, 170 P.3d at 507 (MD can testify to nurse standard of care to administer intramuscular injection where both MD and nurse are qualified to perform procedure); *Creasey*, 637 P.2d 114 (where principles, techniques and methods of practice are the same, practitioner from one discipline may testify in case against practitioner from another discipline); cf. *Simonson*, 225 S.W.3d at 874-75; *In re Stacy K. Boone*, 223 S.W.3d at 407.

173. See cases cited *supra* notes 169-171.

174. BUPPERT, *supra* note 1, at 237 (recognizing that the standard of care for NPs and MDs will be identical in many situations).

175. 968 So. 2d at 243.

176. 223 S.W.3d at 405.

177. *Simonson*, 225 S.W.3d at 872-74.

178. *Id.* at 877.

the standard of care for an NP is the same as an MD when examining or diagnosing a patient.¹⁷⁹ The Court reasoned that because the California legislature recognizes “overlapping functions” between MDs and nurses, “examination” and “diagnosis” of a patient cannot be said as a matter of law to be a function exclusive to MDs.¹⁸⁰ The trial court should have instructed the jury that an NP is held to an NP standard of care.¹⁸¹

E. Rhode Island Standard of Care and Overlapping Functions

Although Rhode Island holds medical professionals to the same standard of care as similarly situated professionals acting in similar circumstances, the Court also recognizes that its focus should be on the acts performed in a malpractice action. To date there are no Rhode Island cases which find that MDs and non-physician health care providers perform overlapping functions. Therefore, there are no cases which hold non-physician health care professionals to the same standard of care as an MD when performing overlapping functions.

As previously discussed, NPs and PAs perform many of the same services as MDs. The main difference between these providers is that PAs always work under the supervision and control of a supervising MD. NPs may or may not work independently. Where an NP is employed in an MD supervised practice, the NP would be similarly situated to the PA. In those circumstances malpractice liability could be attributed to the supervising MD under several different theories of liability. Where an NP is practicing independently, however, it appears that s/he provides overlapping services with a primary care MD. In a malpractice action based on an overlapping function, I believe that the Court would be inclined to hold an independently practicing NP and primary care MD to the same standard of care.

IX. THEORIES OF LIABILITY

Non-physician health care providers can be sued directly for professional malpractice.¹⁸² Where NP or PA services are pro-

179. 695 P.2d 665, 673 (Cal. 1985).

180. *Id.* at 673-74.

181. *Id.* at 674.

182. *See, e.g., Siegel v. Husak*, 943 So. 2d 209 (Fla. Dist. Ct. App. 2006)

vided in collaboration with or under the supervision of an MD, the MD may be sued separately for negligence.¹⁸³ The MD may be directly liable for negligent hiring and retention or negligent supervision.¹⁸⁴ MDs are also held vicariously liable under the doctrine of respondeat superior.¹⁸⁵

An MD-employer may be liable under the theory of negligent hiring or retention where the MD knows, or should have known, that the NP or PA is incompetent or unfit to perform their professional duties.¹⁸⁶ The MD-employer may also be found liable for failing to use reasonable care to discover whether the employee is competent.¹⁸⁷ Thus, MD-employers may be liable for failing to check their employees' references, licensing and certifications or for failing to periodically evaluate their performance.¹⁸⁸

Under the theory of failure to supervise, an MD may be found liable if s/he fails to properly review or oversee the NP or PA.¹⁸⁹ This theory of liability is based on the Restatement (Second) of Agency which states that "[a] person conducting activity through servants or other agents is subject to liability for harms resulting from his conduct if he is negligent or reckless***in the supervision of the activity."¹⁹⁰ In some jurisdictions MDs are legislatively required to provide supervision.¹⁹¹

(NP not individually responsible for misdiagnosis where NP recorded significant information in patient record from which supervising MD could have made correct diagnosis). See generally BUPPERT, *supra* note 1, at 235-48; ROTH-KAUFFMAN, *supra* note 1, at 431-55; McLean, *supra* note 18, at 270.

183. See *supra* note 182.

184. Chris L.Gore, *A Physician's Liability for Mistakes of a Physician Assistant*, 21 J. LEGAL MED. 125, 132-42 (2000).

185. *Id.*; see, e.g., *Adams v. Krueger*, 856 P.2d 864, 867 (1993) (MD liable for NP misdiagnosis under doctrine of respondeat superior).

186. Gore, *supra* note 184, at 140-41.

187. *Id.*

188. *Id.*; McLean, *supra* note 18, at 264-65.

189. Gore, *supra* note 184, at 133-35; McLean, *supra* note 18, at 265-66; see, e.g., *MacDonald v. United States*, 853 F. Supp. 1430, 1438 (M.D. Ga. 1994) (MD liable for failing to supervise PA by only reviewing 10% of patients treated by PA); *Andrews v. United States*, 548 F. Supp. 603, 611-12 (D.S.C. 1982) (MDs at clinic responsible to properly supervise PA who sexually assaulted a patient).

190. RESTATEMENT (SECOND) OF AGENCY § 213 (1958).

191. See, e.g., GA. CODE ANN. § 43-34-26.1 (2008) (MD supervises NP); 244 MASS. CODE REGS. 4.22 (2008) (MD supervises NP); R.I. GEN. LAWS § 5-54-8 (MD supervises PA); 18 VA. ADMIN. CODE § 90-30-120(A) (2008) (NP practices

MDs may also be vicariously liable under the theory of respondeat superior.¹⁹² This doctrine imputes liability for employee negligence to the employer based on the theory that the employee is the agent or is acting for the employer.¹⁹³ In order to prove liability, the plaintiff must show that: an employer-employee relationship existed at the time of the alleged malpractice; the tortfeasor was acting on the MD's orders; and the MD had a right to control the tortfeasor's actions.¹⁹⁴ Liability is easily established against an MD where malpractice is based on PA services because PAs are always acting under the supervision and control of a supervising MD.¹⁹⁵ It is also easier to prove MD liability for NP malpractice under this theory in jurisdictions that legislatively require NP supervision or collaboration with an MD.¹⁹⁶

A. MD Liability in Rhode Island for NP and PA Malpractice

In Rhode Island, MD liability for NP or PA malpractice may be established under the any of the theories listed above.¹⁹⁷ Rhode Island law mandates that all PAs act under the direct supervision and control of an MD.¹⁹⁸ MD supervision requires a written policy agreement between the MD and PA which includes a job description, program for quality assurance, supervision requirements, designated level of supervision, and MD availability for easy communication and referral.¹⁹⁹ Liability for NP malpractice may be similarly attributed to a Rhode Island MD-employer even though the Rhode Island General Laws do not "require" the MD to supervise or collaborate with the NP-employee.²⁰⁰ The employment agreement itself may include its own supervision or

under supervision and direction of MD).

192. Gore, *supra* note 184, at 135-40; McLean, *supra* note 18, at 266-68.

193. Welsh Mfg., Div. of Textron v. Pinkerton's, 474 A.2d 436, 440 (R.I. 1984) (quoting DiCosala v. Kay, 450 A.2d 508, 515 (1982)).

194. McLean, *supra* note 18, at 266.

195. BUPPERT, *supra* note 1, at 10; Roth-Kauffman, *supra* note 1, at 1-2.

196. See Gore, *supra* note 184.

197. See Mainella v. Staff Builders Indus. Services, Inc., 608 A.2d 1141, 1144-45 (R.I. 1992). An employer may be liable for negligent hiring, supervising or retaining an employee if the employer knows or failed to use reasonable care to discover that the employee is unfit. *Id.* at 1144.

198. R.I. GEN. LAWS § 5-54-(8)(a).

199. R.I. GEN. LAWS § 5-54-2(10).

200. R.I. GEN. LAWS § 5-34-3.

collaboration requirements.

X. NP PRIVATE SECTOR REQUIREMENTS

Although the State of Rhode Island allows NPs to provide health care services independent of MD supervision or collaboration, the private sector may impose its own more restrictive requirements. The private sector includes NP employers, hospitals, malpractice insurers and insurance payors. Presently, no Rhode Island hospitals grant NPs admitting privileges. Therefore, if a patient of an independently practicing primary care NP requires hospitalization, s/he must either be admitted under the care of a licensed physician who has admitting privileges at the particular hospital or be cared for by a hospitalist physician.²⁰¹

Private sector restrictions usually require the NP to have a written collaborative or supervision agreement with an MD. Professional liability insurance carriers may only issue malpractice policies to NPs who are employed at MD managed ties.²⁰² Moreover, some insurance payors, like Blue Cross & Blue Shield of Rhode Island, require an independently practicing NP to have a written collaborative agreement with an MD who practices at the same location.²⁰³ Finally, NP employers may limit NP

201. A hospitalist physician is a hospital based physician who cares for patients while they are hospitalized in place of their primary care provider. MedicineNet.com, <http://www.medterms.com/script/main/art.asp?articlekey=8384>.

202. The Medical Malpractice Joint Underwriting Association of Rhode Island (MMJUA of RI) imposes only one requirement on any health care professional seeking professional liability insurance which is that they earn at least 51% of their income in Rhode Island. *Medical Professional Liability Insurance*, MMJUA of Rhode Island, available at <http://www.rhodeislandjua.com/Products.aspx>. Marsh & McLennan Co. has no collaboration requirements for NP professional liability insurance. *Medical Professional Liability Occurrence Insurance Policy*, Interstate Insurance Group, PLJ-2037. *But cf.*, NORCAL Mutual Insurance Co. will only provide professional malpractice insurance to NPs through an MD-employer policy. *Professional Liability Insurance – Group Policy*, NORCAL Mutual Ins. Co., available at http://www.norcalmutual.com/coverages/NORCAL_Group_Policy_Specimen.pdf.

203. In order to become credentialed with Blue Cross Blue & Shield of Rhode Island (BCBSRI) all NPs and PAs must have a “written supervisory/collaborative agreement, which is reviewed by the physician and mid-level practitioner at least annually.” *Requirements for Collaborative Practice (RNP and PA)*, Blue Cross & Blue Shield of Rhode Island (revised 04/08). Al-

scope of practice through the employment contract which may limit duties, impose practice protocols or mandate supervision. Regardless of certain private sector requirements, it is still possible for Rhode Island NPs to practice autonomously.

XI. PUBLIC PERCEPTION

Health care consumers generally assume that the clinician who is treating them is properly trained, competent, and practicing appropriately.²⁰⁴ They believe that the services provided are safe and the practitioner is qualified to perform them.²⁰⁵ Studies show that consumers are generally as satisfied or more satisfied with the services provided by the average primary care NP over the average primary care MD.²⁰⁶

Consumers may also be confused about the professional status of who is treating them. This may be particularly true in states that allow NPs to be addressed as "doctor."²⁰⁷ Moreover, in Oregon, NPs are considered "physicians" for purposes of rendering treatment in workers' compensation cases.²⁰⁸ Even MDs may be confused about NP and PA education and scopes of practice.²⁰⁹ In Rhode Island, for instance, an MD who rendered emergency care at an outside festival believed that a PA who also responded to the incident was another MD.²¹⁰

To complicate the issue further, many nursing schools now offer a "clinical" doctorate of nursing which they argue make their

so, the MD is required to review all significant new problems and new patients on the same day of service. *Id.* The MD and mid-level practitioner must practice at the same physical location and share the same medical records. *Id.*

204. Federation of State Medical Boards, *Assessing the Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety* (2005), available at http://www.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf.

205. *Id.*

206. See Baker, *supra* note 25, at 332; Clive Seale, *Treatment Advice in Primary Care: a Comparative Study of Nurse Practitioners and General Practitioners*, 54 J. ADV. NURSE 534, 540 (2006).

207. Six states allow NPs to be addressed as "doctor." Pearson, *supra* note 29, at 10.

208. *Cook v. Workers' Comp. Dep't*, 758 P.2d 854, 859 (Or. 1988).

209. Joy L. Delman, *The Use and Misuse of Physician Extenders Aiding and Abetting the Unauthorized Practice of Medicine*, 24 J. LEGAL MED. 249, 258, 260 (2003).

210. *Boccasile v. Cajun Music Ltd.*, 694 A.2d 686, 687-89 (R.I. 1997).

graduates “equivalent to primary-care physicians.”²¹¹ These professionals are referred to as “doctor-nurse practitioner” (DrNP) or (DNP). The American Association of Colleges of Nursing distinguishes the care provided by these professionals from MDs, however, by stating that “[n]ursing and medicine are distinct health disciplines that prepare clinicians to assume different roles and meet different practice expectations. DNP programs will prepare nurses for the highest level of nursing practice.”²¹² Apparently, the National Board of Medical Examiners has agreed to develop a certification examination for nurses with doctorate degrees based on the same test physicians take to qualify for a medical license.²¹³ The American Medical Association opposes non-physician scope of practice expansion and has formed a Scope of Practice Partnership to address scope of practice issues.²¹⁴

Consumer perception of the clinician’s professional identity is a factor to consider when deciding whether NPs practice medicine because the purpose of regulating the practice of medicine is to protect the public. For this reason, some states have enacted legislation that requires NPs and other health care providers to wear

211. Laura Landro, *The Informed Patient: Making Room for ‘Dr. Nurse’*, THE WALL STREET JOURNAL, April 2, 2008, at D1; see Cooper, *supra* note 115, at 2; Columbia University School of Nursing, Doctoral Program Overview, http://www.nursing.columbia.edu/programs/doc_prog_overview.html; *contra* Julie A. Stanik-Hutt, *American College of Nurse Practitioners Response to Wall Street Journal Article*, April 9, 2008, available at http://www.acnpweb.org/files/public/WSJ_letter_to_editor.pdf (NPs are not physician practitioners, and since the medical board examination described in the [Wall Street Journal] article [dated April 2, 2008,] is based on the practice of medicine, it is not an appropriate measure of any nurses’ professional expertise. NPs knowledge, skills and abilities are better evaluated by one of the existing national board certification examinations.).

212. American Association of Colleges of Nursing, *Frequently Asked Questions, Position on the Practice Doctorate in Nursing*, <http://www.aacn.nche.edu/DNP/DNPFQA.htm>.

213. Landro, *supra* note 211.

214. Ronald M. Davis, MD, American Medical Association, *From the president*, July 19, 2007, available at <http://www.ama.org/ama/pub/category/17840.html>; American Medical Association, *Report of the Board of Trustees 24-A-06*, available at http://www.acnm.org/siteFiles/legislative/AMA_Board_of_Trustees_Report_24_A_06.pdf; American Association of Family Physicians, *AAFP News Now, Scope of Practice Partnership to Address ‘Doctor-Nurse’ Trend*, 04/03/06, <http://www.aafp.org/online/en/home/publications/news/news-now/professional-issues/20060403scope.html>.

identification that visibly and unambiguously identifies them.²¹⁵

XII. TREND IN HEALTH CARE

Health care is moving from a physician based model to an interdisciplinary model where mid-level practitioners play a substantial role.²¹⁶ As of 2006, there were 110,000 NPs and PAs in the United States comprising one sixth of the medical workforce.²¹⁷ Presently, more than twenty-five percent of all group practices employ NPs and PAs.²¹⁸ They are also in demand at health maintenance organizations and hospitals.²¹⁹

There are several factors that contribute to this trend. One factor is that the number of medical school graduates cannot keep up with rising population.²²⁰ Also, the number of medical school graduates going into primary care is decreasing.²²¹ Additionally, cost and efficacy studies have demonstrated that NPs and PAs can provide a majority of primary care safely and economically.²²²

The trend in using NPs and PAs to perform primary care affects the legal community as well as the medical community. As a Workers' Compensation Court judge, I must determine whether a worker is disabled from work as a result of an injury or illness which is causally related to the workplace. I rely on expert medical opinions to determine diagnosis, causal relationship and disa-

215. See, e.g., CAL. BUS. & PROF. CODE § 680 (West 2003); FLA. STAT. ANN. § 456.072 (t) (West 2008) (separate and different provision held unconstitutional); GA. CODE ANN. § 43-26-6 (c) (2008).

216. See Christian, *supra* note 1; B. G. Druss et al., *Trends in Care by Nonphysician Clinicians in the United States*, N. ENG. J. MED. 130 (2003); Hooker, *supra* note 33, at 4; Richard M. Scheffler et. al., *The Productivity of Physician Assistants and Nurse Practitioners and Health Work Force Policy in the Era of Managed Health Care*, 25 (3) J. ALLIED HEALTH, 207 (Summer 1996).

217. Hooker, *supra* note 33, at 4.

218. *Id.* at 5-6.

219. *Id.*

220. *Id.*

221. *Id.*

222. See *supra* notes 115-17 and accompanying text; Baker, *supra* note 25, at 328 (private health care providers have increasingly recognized the economic advantages of using NPs); Hooker, *supra* note 33, at 5 (PAs and NPs are cost effective); see generally Douglas W. Roblin, *Use of Midlevel Practitioners to Achieve Labor Cost Savings in the Primary Care Practice of an MCO*, 39 (3) Health Serv. Res. 607, June 2004 (it is cost effective to use NPs and PAs in primary care).

bility status. In the past, only MDs were qualified to offer these opinions. Presently, NPs and PAs may be qualified to offer expert medical opinions. Often, I must weigh Pearan MD's opinion against the opinion of an NP or PA. For this reason, it is important to understand the legal status and qualifications of NPs and PAs in order to determine their ability to serve as expert medical witnesses.

XIII. RHODE ISLAND NPS AND PAS AS EXPERT WITNESSES

It is not uncommon for a health care expert in one discipline to testify in a case involving an expert from another discipline.²²³ In any case requiring expert medical testimony, the proffered expert must be qualified in accordance with Rhode Island Rule of Evidence 702: counsel must establish that the expert's education, training, knowledge, skill, and experience qualify her/him to render an expert opinion on the particular matter that is at issue before the court. In all cases, qualification of the expert is within the sound discretion of the trial judge.²²⁴

Once the expert is qualified, s/he must establish the facts upon which s/he relied in rendering an opinion.²²⁵ NPs and PAs can be qualified to proffer opinions concerning diagnosis, causation, disability status and treatment. In medical malpractice cases, they may offer opinions on whether the defendant-practitioner complied with the appropriate standard of care. PAs and NPs who practice under the supervision of, or in collaboration with an MD must establish that their opinions are based on acts or procedures that they are authorized to perform within the scope of their duties. It may even be necessary to introduce the supervisory or collaborative agreement to establish that the NP or PA is testifying about a specifically authorized activity.²²⁶ Expert testimony may be disregarded where counsel neglects to establish that the expert was authorized to perform the services upon which the opinion is

223. See generally *Standard of Care*, *supra* p. 25.

224. *State v. Morales*, 621 A.2d 1247, 1249 (R.I. 1993).

225. Rule 705 of the Rhode Rules of Evidence provides: "Unless the court directs otherwise, before testifying in terms of opinion, an expert witness shall be first examined concerning the facts or data upon which the opinion is based."

226. *Crawford v. Henderson* 589 S.E. 2d 204, 215 (S.C. Ct. App. 2003).

based.²²⁷ In all cases the trier of fact determines how much weight to give each witness' testimony based on all the evidence presented.²²⁸

XIV. DO NPs PRACTICE MEDICINE IN RHODE ISLAND?

What distinguishes NP practice from MD practice is the education, training and knowledge of the individual practitioner. After reviewing the education and training; scopes of practice; and professional services rendered; it is clear that the average MD has more knowledge and training than the average NP, and is generally able to provide a broader spectrum of care. It is equally apparent, however, that the average NP's education and training qualify her/him to safely and effectively provide many of the same services as the average primary care MD. Recognizing that NPs perform many MD functions; courts have allowed NPs to give expert testimony like MDs regarding diagnoses, causal relationship, and disability status.²²⁹

NPs and PAs have become a necessary and integral part of the health care system. In the eyes of the general public they are

227. *Id.* at 214-215.

228. *Kyle v. Pawtucket Redevelopment Agency*, 262 A.2d 636, 638 (R.I. 1970); *see State v. D'Alessio*, 848 A.2d 1118, 1123-24 (R.I. 2004) (notes that the extent of an expert witness' training is a question of weight, not admissibility).

229. *State v. Cookson*, 837 A.2d 101 (Me. 2003) (NP could testify to diagnosis of depression where statute allows NP to make medical diagnosis where practice is delegated by licensed physician even though NP acted independently without supervision. Supreme Judicial Court said it goes to the weight of the testimony and not admissibility); *State v. Lyons*, 725 A.2d 271 (R.I. 1999) (NP specializing in sexual abuse may testify to medical findings); *Rotondo v. Rhode Island Dep't of Human Serv.*, No. Civ.A. 04-1319, 2004 WL 2821640 (R.I. Super. Nov. 12, 2004) (Department of Human Services relies on medical opinions rendered by non-physician health care providers to determine disability per federal regulations); *Crawford*, 589 S.E.2d at 211-215 (NP can testify regarding medical diagnosis and causation; admit written protocols in the future to show NP acted in conformance; physician delegates duties to NP who acts under written protocols); *Newbern v. State*, No. 02-C-01-9106-CR00143, 1992 WL 124459 (Tenn. Crim. App. Aug. 24, 1992) (NP can make medical diagnosis like physician); *cf. Peckham v. Speegle Constr., Inc.*, 896 So. 2d 815 (Fla. Dist. Ct. App. 2005) (PA can opine about disability in workers' compensation case); *In Re Walter R.*, A.2d 346 (Me. 2004) (PA can give expert psychiatric testimony on diagnosis of depression); *contra Keck v. Metrohealth Med. Center*, No. 89526, 2008 WL 519320 (Ohio Ct. App. Feb. 28, 2008) (NP not competent to testify to cause of bedsores).

accepted and trusted primary care providers. Therefore it is important to clearly define the roles of these professionals.

Unfortunately, Rhode Island's legal definition of NP scope of practice is vague. An NP is described as "an advanced practice nurse utilizing independent knowledge of physical assessment and management of health care and illness."²³⁰ The practice "includes. . . collaboration with other health care providers" and also "includes prescriptive privileges."²³¹ We are left to ponder what is meant by these terms. Only NPs who comply with a separate educational requirement may prescribe controlled substances.²³² Therefore, not all NP practice "includes" prescriptive privileges. The term "includes" in this context is a term of "option."²³³ The NP can choose whether or not to have prescriptive privileges "in addition to" physically assessing and managing health care and illness, by presenting evidence to the board of nursing that s/he has completed certain educational requirements in pharmacology. The term "includes" may be similarly interpreted where it concerns collaboration with other health care professionals. Thus, NPs may choose to collaborate with other healthcare professionals, but collaboration is not "required." The term "collaboration" is similarly undefined. Even if one were to apply the Federal definition of this term as it applies to NPs which "requires" an NP to work with an MD under "appropriate supervision," the NP may choose not to "include" collaboration in her/his practice.²³⁴ This is not to suggest that NPs do not appropriately refer, consult or collaborate with other health care professionals. It merely points out the vagueness of the definition.

While the definition of NP is vague, the Rhode Island definition of "practice of medicine" is broad. The "practice of medicine" provides that: "[a]ny person is regarded as practicing medicine *** who holds himself or herself out as being able to diagnose, treat, operate, or prescribe for any person ill or alleged to be ill with disease, pain, injury, deformity or abnormal physical or mental condition, or who either professes to heal, offer or undertake, by any

230. R.I. GEN. LAWS § 5-34-3 (3).

231. *Id.*

232. *See supra* note 65.

233. *See supra* note 15 for definition of "include."

234. *See supra* note 15 for Federal definition of "collaboration."

means or method to diagnose, treat, operate, or prescribe for any person for disease, pain, injury, deformity or physical or mental condition.”²³⁵

Arguably, all advanced practice nurses who use independent judgment along with chiropractors, optometrists, acupuncturists and others may be considered practicing medicine in Rhode Island.²³⁶ The Rhode Island legislature authorizes each of these pro-

235. R.I. GEN. LAWS § 5-37-1 (14) (2004).

236. See, e.g., R.I. GEN. LAWS § 5-29-1 (k) (2004), defines podiatrist as:

“a person licensed as described in this chapter, shall be considered a physician and surgeon of the foot and ankle. For the purposes of reimbursement by and for subscriber benefits/participation agreements with health maintenance organizations, nonprofit medical service corporations, for-profit medical service corporations, and third party insurers, it is unlawful to discriminate against podiatrists.”

The practice of podiatry is defined under R.I. GEN. LAWS § 5-29-1 (l) (2004), as:

“Any person is practicing podiatry within the meaning of this chapter who uses or permits to be used, directly or indirectly, for profit or otherwise, for their own self or for any other person, in connection with their own name, the word ‘podiatrist’ or ‘podiatric physician and surgeon,’ or the title DPM, or any other words, letters, titles, or descriptive matter, personal or not, which directly or indirectly implies the practice of podiatry, or who owns, leases, maintains, or operates a podiatry business in any office or other room or rooms where podiatry operations are performed, or directly or indirectly is manager, proprietor or conductor of the business; or who directly or indirectly informs the public in any language, orally, in writing, or by drawings, demonstrations, specimens, signs, or pictures that he or she can perform or will attempt to perform foot operations of any kind; or who undertakes, by any means or method, gratuitously or for a salary, fee, money, or other reward paid or granted directly or indirectly to himself or herself or to any other person, to diagnose or profess to diagnose, or to treat or profess to treat, or to prescribe for or profess to prescribe for any of the lesions, diseases, disorders, or deficiencies of the pedal extremity. The foot is defined to be the pedal extremity of the human body and its articulations, and shall include the tendons and muscles of the lower leg only as they are involved in the condition of the foot.”

R.I. GEN. LAWS § 5-30-1 (2004), provides as follows:

“For the purpose of this chapter, the practice of ‘chiropractic medicine’ is defined as the science and art of mechanical and material healing as follows: the employment of a system of palpating and adjusting the articulations of the human spinal column and its appendages, by hand and electro-mechanical appliances, and the employment of corrective orthopedics and dietetics for the elimination of the

cause of disease; provided, that chiropractic physicians may not write prescriptions for drugs for internal medication nor practice major surgery as defined in chapter 37 of this title.”

R.I. GEN. LAWS § 5-34-3 (11) (2004), provides as follows:

“Psychiatric and mental health nurse clinical specialist’ is an advanced practice nurse utilizing independent knowledge and management of mental health and illnesses. The practice may include prescription privileges of certain legend medications, controlled substances from Schedule II classified as stimulants, and controlled substances from Schedule IV within the scope of their practice. The practice may include collaboration with other licensed health care professionals, including, but not limited to, psychiatrists, psychologists, physicians, pharmacists, and nurses. The psychiatric and mental health clinical specialist holds the qualifications defined in § 5-34-40.1.”

R.I. GEN. LAWS § 5-35-1 (amended Supp. 2008) provides in pertinent part as follows:

“(a) ‘Optometry’ means the profession whose practitioners are engaged in the art and science of the evaluation of vision and the examination of vision and the examination and refraction of the human eye which includes: the employment of any objective or subjective means for the examination of the human eye or its appendages; the measurement of the powers or range of human vision or the determination of the accommodative and refractive powers of the human eye or the scope of its functions in general and the adaptation of lenses, prisms, and/or frames for the aid of these; the prescribing, directing the use of or administering ocular exercises, visual training, vision training, or orthoptics, and the use of any optical device in connection with these; the prescribing of contact lenses for, or the fitting or adaptation of contact lenses to the human eye; the examination or diagnosis of the human eye to ascertain the presence of abnormal conditions or functions; and the application of pharmaceutical agents to the eye; provided, that no optometrist licensed in this state shall perform any surgery for the purpose of detecting any diseased or pathological condition of the eye. With respect to presently licensed optometrists, only presently licensed optometrists who: (1) have satisfactorily completed a course in pharmacology, as it applies to optometry, at an institution accredited by a regional, professional, or academic accreditation organization which is recognized by the national commission on accreditation, with particular emphasis on the application of drugs to the eye for the purposes of detecting any diseased or pathological condition of the eye; or the effects of any disease or pathological condition of the eye, approved by the board of examiners in optometry and the department; or (2)(i) have successfully passed all sections of the national board of examiners in optometry (NBEO) examination; and (ii) the treatment and management of ocular disease (TMOD) examination, shall be permitted to apply pharmaceutical agents to the eye for the purpose of detecting any diseased or pathological condition of the eye, or the effects of any

professionals to practice within the scope of their professions.²³⁷ These professionals hold themselves out as being able to diagnose and treat illnesses or injuries within the scope of their practices. Therefore, the services rendered by each of them may fall within the legal definition of medical practice.²³⁸

Do NPs "practice medicine" as defined in Rhode Island law? The answer is certainly "yes" where the NP is self-employed or employed in a practice with other NPs and the NP does not maintain any type of a supervision or collaboration agreement with an MD. The answer may be "no" if the NP is employed by an MD and practices under a supervision or collaboration agreement.²³⁹ The issue is one of control; whether the NP is using independent judgment to provide professional services. If s/he is not, the services provided could be considered delegated acts of an MD who is lawfully authorized to practice medicine. Where the services are provided by an independently practicing NP they most assuredly fall within the legal definition of medical practice in Rhode Island.

Unfortunately, it is illegal for anyone other than a licensed physician to practice medicine in Rhode Island.²⁴⁰ Pursuant to

disease or pathological condition of the eye."

R.I. GEN. LAWS § 5-37.2-2(1) defines acupuncture as follows:

"Acupuncture' means the insertion of needles into the human body by piercing the skin of the body, for the purpose of controlling and regulating the flow and balance of energy in the body."

The legislature recognizes acupuncture as a "healing art." *Id.* The term "healing art" is not defined.

237. See *supra* note 235.

238. See *supra* note 234 and accompanying text.

239. *Prof'l Health Care, Inc. v. Bigsby*, 709 P.2d 86 (Colo. Ct. App. 1985) (NP acting within established protocols under MD supervision is not practicing medicine); *Sermchief v. Gonzales*, 660 S.W.2d 683 (Mo. 1983) (nurse not practicing medicine when acting under MD's standing orders); *Montana Soc'y of Anesthesiologists v. Montana Bd. of Nursing*, 171 P.3d 704 (Mont. 2007) (independent certified registered nurse anesthetist practice is not practice of medicine).

240. R.I. GEN. LAWS § 3-37-12 (2004), provides as follows:

"Any person who is not lawfully authorized to practice medicine within this state, and registered according to law, who practices medicine or surgery or attempts to practice medicine or surgery, or any of the branches of medicine or surgery, after having received or with the intent of receiving, either directly or indirectly, any bonus, gift or compensation, or who opens an office with intent to practice medicine, or holds himself or herself out to the public as a practitioner of medicine, whether by appending to his or her name the title

R.I. Gen Laws § 5-37-2, only physicians who have graduated from an approved medical school, completed post graduate training requirements and passed a national certification examination may practice medicine. In order to rectify this legislative inconsistency, Rhode Island must either redefine the “practice of medicine” or exempt NPs and other health care providers from it. I believe that the appropriate legislative solution is to exempt NP practice from the practice of medicine. This solution does not preclude the court from finding that NPs perform many of the same professional services as MDs, nor does it preclude the court from holding NPs to the same standard of care as MDs when performing overlapping functions. Rather, it acknowledges that NP practice falls within the scope of medical practice, yet it distinguishes NPs from MDs based on their education and training.

From a public policy viewpoint, regardless whether NP practice is or is not considered practicing medicine, NPs should be held to the same standard of care as MDs when performing overlapping professional services. The reasons for this are quite simple. First, both professionals are essentially relying on the same methods of practice including similar clinical evaluations and diagnostic tests.²⁴¹ Second, both employ the same treatment modalities including prescriptive medication and other therapeutic treatment.²⁴² Third, holding NPs to the same standard of care as MDs when performing overlapping duties will help regulate the profession and maintain high quality health care.²⁴³ Finally, the general public has the right to expect that all state licensed medical professionals who are authorized to provide particular professional services are equally competent to do so.

doctor or any abbreviation, or M.D., or any other title or designation implying a practitioner of medicine, or in any other way, shall be imprisoned not more than three (3) years, or fined not more than one thousand dollars (\$1,000), or shall suffer both fine and imprisonment; and in no case when any provision of this chapter has been violated shall the person violating these provisions be entitled to receive compensation for services rendered.”

241. See Professional Services, *supra* p. 17.

242. *Id.*

243. See generally Coleman, *supra* note 38.

XV. PROPOSED LEGISLATION

The proposed legislation exempts NP practice from the practice of medicine. It also amends the definition of NP which will clarify their role as primary care providers within the scope of their education and training. Additionally, it acknowledges NPs as secondary and tertiary care providers under appropriate supervision or collaboration.

I also propose including NPs in certain legislation that presently only applies to primary care MDs. I believe that many of the same legislative requirements and protections should apply to NPs because they are also primary care providers. The proposed legislation contained in Appendix I, will resolve present conflicts and will further clarify the NP's role in Rhode Island.²⁴⁴

244. R.I GEN. LAWS § 5-37-2 (Supp. 2008), provides in pertinent part as follows:

“(a)(1) Authority to practice allopathic or osteopathic medicine under this chapter shall be by a license issued by the director of the department of health to any reputable physician who intends to practice allopathic or osteopathic medicine in this state, and who meets the requirements for licensure established in this chapter and regulations established by the board or by the director. Applicants for licensure shall present satisfactory evidence of graduation from a medical school or school of osteopathic medicine approved by the board and in good standing, shall meet post graduate training requirements and any other requirements that the board or director establishes by regulation, and shall pass in a satisfactory manner any examination that the board may require. Any physician applying for licensure shall pay an application fee of five hundred and seventy dollars (\$570) and that fee shall in no case be returned. Applicants requiring reexamination shall submit a fee of five hundred and seventy dollars (\$570) for each reexamination.

(2) A license to practice allopathic medicine shall be issued to persons who have graduated from a school of medicine, possess a degree of doctor of medicine (or meet the requirements of subsection (b) of this section), and meet the requirements for licensure.

(3) A license to practice osteopathic medicine shall be issued to persons who have graduated from a school of osteopathic medicine and possess a degree of doctor of osteopathy and otherwise meet the requirements for licensure. A license to practice osteopathic medicine shall confer upon the holder the right to practice osteopathic medicine in all its branches as taught and practiced in accredited colleges of osteopathic medicine. The holder of that license shall be subject to the same duties and liabilities and entitled to the same rights and privileges, which may be imposed by law or governmental regulation, upon physicians of any school of medicine.”

In addition to the above referenced changes, Appendix I addresses many other aspects of NP practice. For instance, under a durable power of attorney, terminally ill patients will have the right to authorize their primary care NP to issue a do not resuscitate order and to withhold or withdraw life support. The NP will be immunized from liability when complying with the durable power of attorney.

The proposed legislation requires NPs to wear identification tags when rendering professional services which will clearly identify them by name and professional status. Legislation concerning prescriptive privileges that previously applied only to MDs will also apply equally to NPs. NPs will be required to clearly identify themselves on prescription slips and each prescription will authorize a generic equivalent unless a brand name is specified. NPs will be subject to the same penalties as physicians for violating these provisions. NPs will also be forbidden from issuing blank prescriptions and fee splitting.

Additionally, NPs will be required to provide notice to patients where the NP does not participate in a medical insurance plan, and retiring or deceased NPs will be required to preserve or transfer medical records. The proposed legislation also imposes quality assurance, reporting, confidentiality and screening requirements concerning such matters as mammograms, pap smears, gun shot wounds, scoliosis, sexually transmitted or infectious diseases, rodent control and lead paint poisoning. It allows the admission of deceased NPs' records in workers' compensation cases. Finally, health plans will be required to provide written notice before materially modifying the terms of their participating agreement with an NP and will allow the NP to amend or terminate her/his contract with the health plan.

XVI. CONCLUSION

In Rhode Island, NPs are authorized to practice autonomously, using their independent judgment to provide many of the same professional services as primary care MDs. They have become an integral part of our health care system. It is predicted that the number of NPs and PAs rendering primary care will continue to increase in the future due to economics and increasing population. While education and training distinguish the average NP from the average MD, efficacy studies demonstrate that NPs are capable of

providing overlapping services with comparable outcomes.

It is the state's prerogative to regulate health care. In doing so, the state recognizes that health care professional services are dynamic and changing. Current Rhode Island legislation provides an imprecise definition of NP and a broad definition of medical practice. As a result, NP authorized professional services could be considered practicing medicine which is legislatively prohibited for anyone but a licensed physician.

Rhode Island must recognize that an interprofessional intersection exists where NPs and MDs render overlapping services. Therefore, NP practice should be exempt from the legislative definition of the practice of medicine. Nevertheless, NPs should be held to the same standard of care as MDs when performing overlapping services. The standard of care should be based on the service performed rather than the status of the professional performing the service.

The legislature should amend current legislation to unambiguously define and regulate NP practice. This will ensure that health and safety regulations apply equally to all primary care providers. Requiring consistent practices among health professionals who provide overlapping services will produce high quality health care for society.

APPENDIX I: PROPOSED LEGISLATIVE AMENDMENTS

Note: All proposed language is underlined and all stricken language has a ~~strike~~ through it.

Title 5 Businesses and Professions**Chapter 5-34 - Nurses****5-34-3 Definitions.**

As used in this chapter:

(1) "Advanced practice nurse" means the status of qualified individuals who hold an active license as a registered nurse and an active license as a nurse in an advanced role as defined under the provisions of this chapter or chapter 5-34.2.

(2) "Approval" means the process where the board of nursing evaluates and grants official recognition to basic nursing education programs meeting established criteria and standards.

(3) "Board" means the Rhode Island board of nurse registration and nursing education or any committee or subcommittee thereof.

~~(3)~~ (4) "Certified registered nurse practitioner" or "nurse practitioner" is an advanced practice nurse utilizing who uses independent knowledge of physical assessment and management of health care and illnesses. The practice includes prescriptive privileges. The practice includes collaboration with other licensed health care professionals including, but not limited to, physicians, pharmacists, podiatrists, dentists and nurses. to deliver primary, secondary or tertiary care within the nurse practitioner's knowledge, education, training and certification pursuant to secs. 5-34-35 and 5-34-39. Nurse practitioners provide secondary and tertiary care in collaboration with other specialty health professionals who are licensed and certified to deliver the same secondary and tertiary care.

(5) "Collaboration" means the nurse practitioner works with other specialty health professionals to deliver appropriate professional services within the scope of the nurse practitioner's professional expertise.

~~(4)~~ (6) "Department" means the department of health.

~~(5)~~ (7) "Health" means optimum well-being.

~~(6)~~ (8) "Healthcare" "Health care" means those services provided to promote the optimum well-being of individuals.

(7) (9) "Licensed" means the status of qualified individuals who have completed a designated process by which the board of nursing grants permission to individuals accountable and/or responsible for the practice of nursing and to engage in that practice, prohibiting all others from legally doing so.

(8) (10) "Nursing" means the provision of services that are essential to the promotion, maintenance, and restoration of health throughout the continuum of life. It provides care and support of individuals and families during periods of wellness, illness, and injury, and incorporates the appropriate medical plan of care prescribed by a licensed physician, dentist, or podiatrist. It is a distinct component of health services. Nursing practice is based on specialized knowledge, judgment, and nursing skills acquired through educational preparation in nursing and in the biological, physical, social, and behavioral sciences.

(9) (11) "Practical nursing" is practiced by licensed practical nurses (L.P.N.s). It is an integral part of nursing based on a knowledge and skill level commensurate with education. It includes promotion, maintenance, and restoration of health and utilizes standardized procedures leading to predictable outcomes, which are in accord with the professional nurse regimen under the direction of a registered nurse. In situations where registered nurses are not employed, the licensed practical nurse functions under the direction of a licensed physician, dentist, podiatrist or other licensed health care providers authorized by law to prescribe. Each L.P.N. is responsible for the nursing care rendered.

(12) "Primary care", as defined by the Institute of Medicine, means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

(10) (13) "Professional nursing" is practiced by registered nurses (R.N.s). The practice of professional nursing is a dynamic process of assessment of an individual's health status, identification of health care needs, determination of health care goals with the individual and/or family participation and the development of a plan of nursing care to achieve these goals. Nursing actions, including teaching and counseling, are directed toward the promotion, maintenance, and restoration of health and evaluation of the

individual's response to nursing actions and the medical regimen of care. The professional nurse provides care and support of individuals and families during periods of wellness and injury, and incorporates where appropriate, the medical plan of care as prescribed by a licensed physician, dentist or podiatrist or other licensed health care providers authorized by law to prescribe. Each R.N. is directly accountable and responsible to the consumer for the nursing care rendered.

(14) "Professional services" for purposes of title 5, means the rendering of personal services by a person licensed to practice a health care profession.

~~(14)~~ (15) "Psychiatric and mental health nurse clinical specialist" is an advanced practice nurse utilizing independent knowledge and management of mental health and illnesses. The practice may include prescription privileges of certain legend medications, controlled substances from Schedule II classified as stimulants, and controlled substances from Schedule IV within the scope of their practice. The practice may include collaboration with other licensed health care professionals, including, but not limited to, psychiatrists, psychologists, physicians, pharmacists, and nurses. The psychiatric and mental health clinical specialist holds the qualifications defined in § 5-34-40.1.

(16) "Secondary care" is treatment provided by a licensed and certified health care specialist.

(17) "Tertiary care" is treatment provided at a health care center that includes highly trained health care specialists.

5-34-38.1 Identification of certified registered nurse practitioner.

Any person who is licensed as a certified registered nurse practitioner shall identify that he or she is so licensed by displaying either the title "certified registered nurse practitioner" or "nurse practitioner," or the abbreviation "R.N.P.," on a name tag or other similar form of identification during times when such person is providing direct patient care.

5-34-39.1 Prescription slips.

Every prescription slip issued by a certified registered nurse practitioner shall contain the clearly-printed name and address of the issuing practitioner. In addition, every prescription written in this state shall have one line for the practitioner's signature.

5-34-39.2 Certified registered nurse practitioners required to authorize product selection.

Every certified registered nurse practitioner, when prescribing any drug by brand name, shall in each prescription, oral, written or electronic, authorize a less expensive generic equivalent drug product by signing the prescription. If, in the professional judgment of the prescribing practitioner, the brand name is medically necessary, the practitioner shall indicate "brand name necessary" on the prescription form. Pursuant to § 42-127.1-7 and chapter 19.1 of this title, an electronic signature shall satisfy this requirement.

5-34-39.3 Penalty for violating § 5-34-19.1 or 5-34-19.2.

Any person, firm or corporation, who violates any of the provisions of § 5-34-19.1 or 5-34-19.2 shall be fined not more than one hundred dollars (\$100) for each violation.

5-34-39.4 Blank prescriptions.

Any certified registered nurse practitioner who signs a prescription in blank and delivers it to a patient or any other person except a duly licensed pharmacist shall be fined no more than five hundred dollars (\$500).

5-34-39.5 Fee splitting.

No certified registered nurse practitioner shall directly or indirectly receive payment, reimbursement, compensation, or fee for a referral to any clinical laboratory. A violation of the provisions of this section shall constitute a misdemeanor and upon conviction thereof may be punished by imprisonment for not longer than one year or a fine of not more than five hundred dollars (\$500), or both.

5-34-39.6 Disclosures.

(a)(1) Any certified registered nurse practitioner who is not a participant in a medical insurance plan shall post a notice, in a conspicuous place in his or her medical offices where it can be read by his or her patients, which reads, in substance, as follows:

"To my patients:

I do not participate in a medical insurance plan. You should know that you shall be responsible for the payment of my professional fees."

(2) Any certified registered nurse practitioner who fails to post this notice shall not be entitled to charge his or her patients any amount for professional fees in excess of that allowed had the

practitioner participated in a medical insurance plan.

(b) Every certified registered nurse practitioner shall disclose to patients eligible for Medicare, in advance of treatment, whether the practitioner accepts assignment under Medicare reimbursement as payment in full for professional services and/or treatment in the practitioner's office. This disclosure shall be given by posting in each practitioner's office, in a conspicuous place, a summary of the practitioner's Medicare reimbursement policy. Any practitioner who fails to make the disclosure as required in this section shall not be allowed to charge the patient in excess of the Medicare assignment amount for the professional procedure performed.

(c) When a patient requests, in writing, that his or her medical records be transferred to another certified registered nurse practitioner, physician or medical practice group, the original certified registered nurse practitioner or nurse practitioner practice group shall promptly honor the request. The certified registered nurse practitioner or nurse practitioner practice group shall be reimbursed for reasonable expenses (as defined by the director pursuant to § 23-1-48) incurred in connection with copying the medical records.

(d) Every certified registered nurse practitioner or nurse practitioner practice group shall, upon written request of any patient (or his or her authorized representative as defined in § 5-37.3-3(1)) who has received health care services from the certified registered nurse practitioner or nurse practitioner practice group, at the option of the certified registered nurse practitioner or nurse practitioner practice group either permit the patient (or his or her authorized representative) to examine and copy the patient's confidential health care information, or provide the patient (or his or her authorized representative) a summary of that information. If the certified registered nurse practitioner or nurse practitioner practice group decides to provide a summary and the patient is not satisfied with a summary, then the patient may request, and the certified registered nurse practitioner or nurse practitioner practice group shall provide, a copy of the entire record. At the time of the examination, copying or provision of summary information, the certified registered nurse practitioner or nurse practitioner practice group shall be reimbursed for reasonable expenses (as defined by the director pursuant to § 23-1-48) in connection with copying this information. If, in the professional judgment of

the treating certified registered nurse practitioner, it would be injurious to the mental or physical health of the patient to disclose certain confidential health care information to the patient, the certified registered nurse practitioner or nurse practitioner practice group shall not be required to disclose or provide a summary of that information to the patient, but shall upon written request of the patient (or his or her authorized representative) disclose that information to another certified registered nurse practitioner, nurse practitioner practice group, physician or medical practice group designated by the patient.

(e) Every certified registered nurse practitioner who has ownership interest in health facilities or laboratories, including any health care facility licensed pursuant to chapter 17 of title 23, any residential care/assisted living facility licensed pursuant to chapter 17.4 of title 23, any adult day care program licensed or certified by the director of the department of elderly affairs, or any equipment not on the certified registered nurse practitioner's premises, shall, in writing, make full patient disclosure of his or her ownership interest in the facility or therapy prior to utilization. The written notice shall state that the patient has free choice either to use the certified registered nurse practitioner's proprietary facility or therapy or to seek the needed professional services elsewhere.

(f) Unless otherwise expressly stated in writing by the nurse practitioner practice group, all medical records shall be the property of the nurse practitioner practice group with which a certified registered nurse practitioner is associated when that nurse practitioner created all such medical records. A nurse practitioner practice group shall provide patients with access to patients' medical records in the same manner as is required of individual nurse practitioner's under this chapter. To the extent a nurse practitioner practice group fails to provide access to patients in accordance with the requirements of this chapter, the individual officers of the nurse practitioner practice group (or in the absence of officers, the shareholders or owners of the nurse practitioner practice group), in their capacities as licensees of the board, shall be subject to the disciplinary powers of the board.

5-34-39.7 Closure of nurse practitioner practice - Preservation of records.

(a) A certified registered nurse practitioner shall, at least ni-

nety (90) days before closing his or her practice, give public notice as to the disposition of patients' medical records in a newspaper with a statewide circulation, and shall notify the Rhode Island board of nurse registration and nursing education of the location of the records. The public notice shall include the date of the nurse practitioner's retirement, and where and how patients may obtain their records both prior to and after closure of the nurse practitioner's practice.

(b) The heirs or estate of a deceased nurse practitioner who had been practicing at the time of his or her death shall, within ninety (90) days of the nurse practitioner's death, give public notice as to the disposition of patients' medical records in a newspaper with a statewide circulation, and shall notify the Rhode Island board of nurse registration and nursing education of the location of the records.

(c) Any nurse practitioner closing his or her practice, or the heirs or estate of a deceased nurse practitioner who had been practicing at the time of his or her death, shall dispose of the nurse practitioner's patient records in a location and manner so that the records are maintained and accessible to patients.

(d) Any person or corporation or other legal entity receiving medical records of any retired nurse practitioner or deceased nurse practitioner who had been practicing at the time of his or her death, shall comply with and be subject to the provisions of chapter 37.3 of this title, the Confidentiality of Health Care Information Act, and shall be subject to the rules and regulations promulgated in accordance with § 23-1-48 and with the provisions of § 5-34-19.6 (c) and (d), even though this person, corporation, or other legal entity is not a physician or nurse practitioner.

5-34-39.8 Mammograms - Quality assurance standards.

Any certified registered nurse practitioner interpreting a mammogram must meet state-approved quality assurance standards for interpreting mammograms. The director of the department of health has the authority to promulgate rules and regulations necessary to carry out the provisions of this section.

5-34-39.9 Pap smears - Quality assurance standards.

Any certified registered nurse practitioner taking a pap smear or supervising the taking of a pap smear shall submit the smear for processing only to a laboratory which is licensed by the Rhode Island department of health specifically to perform cervical cytol-

gy, or is accredited by the American Society of Cytology, or is accredited by the College of American Pathologists, or is a hospital accredited by the joint commission for the accreditation of health care organizations, or is a hospital accredited by the American Osteopathic Association.

Title 5 Businesses and Professions

Chapter 5-37 – Board of Medical Licensure and Discipline

5-37-1 Definitions.

As used in this chapter:

(1) “Board” means the Rhode Island board of medical licensure and discipline or any committee or subcommittee thereof.

(2) “Chief administrative officer” means the administrator of the Rhode Island board of medical licensure and discipline.

(3) “Department” means the Rhode Island department of health.

(4) “Director” means director of the Rhode Island department of health.

(5) “Health care facility” means any institutional health service provider licensed pursuant to the provisions of chapter 17 of title 23.

(6) “Health maintenance organization” means a public or private organization licensed pursuant to the provisions of chapter 17 of title 23 or chapter 41 of title 27.

(7) “Limited registrant” means a person holding a limited registration certificate pursuant to the provisions of this chapter.

(8) “Medical malpractice” or “malpractice” means any tort, or breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider listed in § 7-5.1-2 or by a ~~physician, dentist,~~ hospital, clinic, health maintenance organization or professional service corporation providing health care services and organized under chapter 5.1 of title 7, to a patient or the rendering of medically unnecessary services except at the informed request of the patient.

(9) “Medical practice group” means a single legal entity formed primarily for the purpose of being a physician group practice in any organizational form recognized by the state in which the group practice achieves its legal status, including, but not li-

mitted to, a partnership, professional corporation, limited liability company, limited liability partnership, foundation, not-for-profit corporation, faculty practice plan, or similar association.

(10) "Nonprofit medical services corporation" or "nonprofit hospital service corporation" means any corporation organized pursuant to chapter 19 or chapter 20 of title 27 for the purpose of establishing, maintaining, and operating a nonprofit medical service plan.

(11) "Peer review board" means any committee of a state or local professional association or society including a hospital association, or a committee of any licensed health care facility, or the medical staff thereof, or any committee of a medical care foundation or health maintenance organization, or any committee of a professional service corporation or nonprofit corporation employing twenty (20) or more practicing professionals, organized for the purpose of furnishing medical service, or any staff committee or consultant of a hospital service or medical service corporation, the function of which, or one of the functions of which is to evaluate and improve the quality of health care rendered by providers of health care service or to determine that health care services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health care services in the area and shall include a committee functioning as a utilization review committee under the provisions of 42 U.S.C. § 1395 et seq. (Medicare law) or as a professional standards review organization or statewide professional standards review council under the provisions of 42 U.S.C. § 1301 et seq. (professional standards review organizations) or a similar committee or a committee of similar purpose, to evaluate or review the diagnosis or treatment of the performance or rendition of medical or hospital services which are performed under public medical programs of either state or federal design.

(ii) "Peer review board" also means the board of trustees or board of directors of a state or local professional association or society, a licensed health care facility, a medical care foundation, a health maintenance organization, and a hospital service or medical service corporation only when such board of trustees or board of directors is reviewing the proceedings, records, or recommendations of a peer review board of the above enumerated organiza-

tions.

(12) "Person" means any individual, partnership, firm, corporation, association, trust or estate, state or political subdivision, or instrumentality of a state.

(13) "Physician" means a person with a license to practice allopathic or osteopathic medicine in this state under the provisions of this chapter.

(14) "Practice of medicine" includes the practice of allopathic and osteopathic medicine. Any person is regarded as practicing medicine within the meaning of this chapter who holds himself or herself out as being able to diagnose, treat, operate, or prescribe for any person ill or alleged to be ill with disease, pain, injury, deformity or abnormal physical or mental condition, or who either professes to heal, offer or undertake, by any means or method to diagnose, treat, operate, or prescribe for any person for disease, pain, injury, deformity or physical or mental condition. In addition, one who attaches the title, M.D., physician, surgeon, D.O., osteopathic physician and surgeon, or any other similar word or words or abbreviation to his or her name indicating that he or she is engaged in the treatment or diagnosis of the diseases, injuries or conditions of persons shall be held to be engaged in the practice of medicine.

5-37-12.1 Certified registered nurse practitioner exemption from practice of medicine

All certified registered nurse practitioners as defined in § 5-34-3, shall not be regarded as practicing medicine when providing services within the scope of their professional practice.

Title 9 Courts and Civil Procedure – Procedure Generally

Chapter 9-19 Evidence

9-19-41 Expert witnesses in malpractice cases.

In any legal action based upon a cause of action arising on or after January 1, 1987, for personal injury or wrongful death filed against a licensed physician, certified registered nurse practitioner, hospital, clinic, health maintenance organization, professional service corporation providing health care services, dentists, or dental hygienist based on professional negligence, only those persons who by knowledge, skill, experience, training, or education qualify as experts in the field of the alleged malpractice shall be

permitted to give expert testimony as to the alleged malpractice.

9-19-29 Admissibility of records of deceased physicians, dentists and professional engineers.

(a) In all actions for the recovery of benefits under the Workers' Compensation Act, chapters 29 - 38 of title 28, for personal injury or death, and in all actions for the recovery of damages for personal injury or death in any civil proceeding, if a physician, dentist, nurse practitioner, or professional engineer has died prior to the time of the trial of the action, the written records, reports, or bills of the physician, nurse practitioner, or dentist concerning the patient who suffered the injury or death, and the reports and scale drawings of the professional engineer concerning matter relevant to the circumstances under which the injury or death was sustained, shall be admissible in evidence.

(b) In all actions for the recovery of benefits under the Workers' Compensation Act for personal injury or death and in all actions for the recovery of damages for personal injury or death in any civil proceeding, if a physician, dentist, nurse practitioner, or professional engineer has moved out of this state prior to trial or cannot be located within this state after a reasonable search, and whose whereabouts and address are unknown, any written records, reports, or bills of the physician, nurse practitioner, or dentist concerning the patient who suffered the injury or death, and the reports and scale drawings of the professional engineer concerning matter relevant to the circumstances under which the injury or death was sustained, shall be admissible in evidence and the patient may testify as to the medical or dental services provided and the treatment received, and another physician, nurse practitioner, or dentist may provide evidence as to the medical or dental services or treatment as if the physician, nurse practitioner, or dentist had been the one who rendered the services or treatment, including evidence as to the fair and reasonable charge for the services, the necessity of the services or treatment and any other matter.

Title 11 Criminal Offenses

Chapter 11-47 Weapons

11-47-48 Report of gunshot wounds.

Every physician or nurse practitioner attending or treating a case of bullet wound, gunshot wound, powder burn, or any other

injury arising from or caused by the discharge of a gun, pistol, or other firearm, or whenever any case is treated in a hospital, sanitarium, dispensary, or other institution the person in charge of it, shall report the case at once to the police authorities of the town or city where the physician, nurse practitioner, hospital, sanitarium, dispensary or institution is located. This section shall not apply to wounds, burns, or injuries received by any member of the armed forces of the United States or of this state while engaged in the actual performance of duty. Whoever violates any provision of this section shall be punished by a fine of not less than fifty dollars (\$50.00) nor more than one hundred dollars (\$100).

Title 16 Education

Chapter 16-21 Health and Safety of Pupils

16-21-10 Scoliosis screening.

The school health program shall provide for the yearly screening or examination for scoliosis of all school children in grades six (6) through eight (8) and the preservation of records of the screening or examinations of those children. The parent or guardian of any child in grades six (6) through eight (8) may have the screening or examination conducted by a private physician or nurse practitioner, and the results shall be made available to the local school department. Otherwise, the screening shall be conducted by a certified nurse-teacher. The screening of male and female pupils shall be conducted separately. The parent or guardian of any child who is found to have positive signs or symptoms of scoliosis shall be notified of the findings. However, the test shall not be required of any student whose parents or guardian objects on the ground that the test conflicts with their religious belief.

Title 23 Health and Safety

Chapter 23-4.10 Health Care Power of Attorney

23-4.10-1 Purpose.

(a) The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care.

(b) In order that the rights of patients may be respected even after they are no longer able to participate actively in decisions about themselves, the legislature declares that the laws of the state shall recognize the right of an adult person to make a writ-

ten durable power of attorney which might include instructing his or her physician or nurse practitioner to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

23-4.10-1.1 Definitions.

The following definitions govern the construction of this chapter:

(1) "Advance directive protocol" means a standardized, state-wide method developed for emergency service personnel by the department of health and approved by the ambulance service advisory board, of providing palliative care to, and withholding life-sustaining procedures from, a qualified patient.

(2) "Artificial feeding" means the provision of nutrition or hydration by parenteral, nasogastric, gastric, or any means other than through per oral voluntary sustenance.

(3) "~~Attending physician~~" "Attending clinician" means the physician or nurse practitioner, who has primary responsibility for the treatment and care of the patient.

(4) "Director" means the director of health.

(5) "Durable power of attorney" means a witnessed document executed in accordance with the requirements of § 23-4.10-2.

(6) "Emergency medical services personnel" means paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians, or other emergency services personnel acting within the ordinary course of their professions.

(7) "Health-care provider" means a person who is licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession.

(8) "Life-sustaining procedure" means any medical procedure or intervention that, when administered to a patient, will serve only to prolong the dying process. "Life-sustaining procedure" shall not include any medical procedure or intervention considered necessary by the attending physician or emergency service personnel to provide comfort, care, or alleviate pain.

(9) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, government, governmental subdivision or agency, or any other legal entity.

(10) "Physician and/or doctor" means an individual licensed to practice medicine in this state.

(11) "Nurse practitioner" means an individual licensed as a

certified registered nurse practitioner pursuant to § 5-34-3.

(11) (12) "Terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death.

23-4.10-2 Statutory form of durable power of attorney.

The statutory form of durable power of attorney is as follows:

**STATUTORY FORM DURABLE POWER OF ATTORNEY
FOR HEALTH CARE**

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen (18) years of age and a resident of the state for this document to be legally valid and binding.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent:

- (1) Authorizes anything that is illegal,
- (2) Acts contrary to your known desires, or
- (3) Where your desires are not known, does anything that is clearly contrary to your best interests.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death except to inform your family or next of kin of your desire, if any, to be an organ and tissue owner.

You have the right to revoke the authority of your agent by notifying your agent or your treating ~~doctor~~ clinician, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

(1) DESIGNATION OF HEALTH CARE AGENT. I,

(insert your name and address)

do hereby designate and appoint:

(insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider, (2) a nonrelative employee of your treating health care provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility.) as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

(2) CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable

power of attorney for health care.

(3) **GENERAL STATEMENT OF AUTHORITY GRANTED.** Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures and informing my family or next of kin of my desire, if any, to be an organ or tissue donor.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph (4) ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

(4) **STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.** (Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

(a) Statement of desires concerning life-prolonging care, treatment, services, and procedures:

(b) Additional statement of desires, special provisions, and li-

mitations regarding health care decisions:

(c) Statement of desire regarding organ and tissue donation:

Initial if applicable:

[] In the event of my death, I request that my agent inform my family/next of kin of my desire to be an organ and tissue donor, if possible.

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

(5) INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph (4) ("Statement of desires, special provisions, and limitations") above.)

(6) SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital, ~~or~~ physician, or nurse practitioner.

(7) DURATION. (Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)

This durable power of attorney for health care expires on

(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

(8) DESIGNATION OF ALTERNATE AGENTS. (You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same

health care decisions as the agent you designated in paragraph (1), above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph (1) is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

(A) First Alternate Agent:

(Insert name, address, and telephone number of first alternate agent.)

(B) Second Alternate Agent:

(Insert name, address, and telephone number of second alternate agent.)

(9) **PRIOR DESIGNATIONS REVOKED.** I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on _____ at

(Date) (City)

(State) _____

(You sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY ONE NOTARY PUBLIC OR TWO (2) QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

STATEMENT OF WITNESSES

(This document must be witnessed by two (2) qualified adult witnesses or one (1) notary public. None of the following may be used as a witness:

- (1) A person you designate as your agent or alternate agent,
- (2) A health care provider,
- (3) An employee of a health care provider,
- (4) The operator of a community care facility,
- (5) An employee of an operator of a community care facility.

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Option 1 - Two (2) Qualified Witnesses:

Signature: _____ Residence Address:

Print Name: _____

Date: _____

Signature: _____ Residence Address:

Print Name: _____

Date: _____

Option 2 - One Notary Public

Signature: _____, Notary Public

Print Name: _____

Date: _____

My commission expires on: _____

(AT LEAST ONE OF THE ABOVE WITNESSES OR THE NOTARY PUBLIC MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature:

Print Name:

23-4.10-3 Revocation.

(a) A durable power of attorney may be revoked at any time and in any manner by which the declarant is able to communicate an intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending physician clinician or any health care provider or emergency medical services personnel upon communication to ~~that physician~~ the attending clinician or health care provider or emergency medical services personnel by the declarant or by another who witnessed the revocation.

(b) The attending physician clinician or health care provider shall make the revocation a part of the declarant's medical record.

(c) For emergency medical services personnel, the absence of reliable documentation shall constitute a revocation of a durable power of attorney.

23-4.10-4 Recording contents of durable power of attorney.

The attending physician clinician who had knowledge of the existence of a durable power of attorney shall note in the medical record the existence of the durable power of attorney. In the instance where the durable power of attorney includes a DNR (do not resuscitate) order, that should also be entered into the medical record.

23-4.10-5 Treatment of patients.

(a) A patient has the right to make decisions regarding use of life sustaining procedures as long as the patient is able to do so. If a patient is not able to make those decisions, the durable power of attorney governs decisions regarding use of life sustaining procedures.

(b) This chapter does not prohibit any action considered necessary by the attending physician clinician, health care provider, or emergency medical services personnel for comfort, care, or alleviation of pain.

(c) The durable power of attorney of a patient known to the attending physician clinician to be pregnant shall be given no force or effect as long as it is probable that the fetus could develop to the point of live birth with continued application of life sustaining procedures.

23-4.10-6 Transfer of patients.

An attending ~~physician~~ clinician or health-care provider who refuses to comply with the durable power of attorney of a patient pursuant to this chapter shall make the necessary arrangements to effect the transfer of the patient to another physician who will effectuate the durable power of attorney of the patient.

23-4.10-7 Immunities.

(a) In the absence of actual notice of the revocation of a durable power of attorney, the following, while acting in accordance with the requirements of this chapter, are not subject to civil or criminal liability or charges of unprofessional conduct:

(1) A physician or nurse practitioner who acts pursuant to the terms of a durable power of attorney or at the direction of the agent so designated by a durable power of attorney.

(2) A person who acts under the direction or with the authorization of a physician or nurse practitioner.

(3) The health-care provider owning or operating the facility in which the terms of durable power of attorney are implemented.

(4) Emergency medical services personnel who act pursuant to an advanced directive protocol.

(5) Emergency medical services personnel who proceed to provide life-sustaining treatment to a patient pursuant to a revocation communicated to them.

(6) An agent acting in accordance with a valid durable power of attorney.

(b) A physician or nurse practitioner is not subject to civil or criminal liability for actions under this chapter which are in accordance with reasonable medical standards.

23-4.10-8 Penalties.

(a) Failure of a physician or nurse practitioner to transfer a patient pursuant to § 23—6 shall constitute “unprofessional conduct” as that term is used in § 5-37-5.1.

(b) Any person who willfully conceals, cancels, defaces, or obliterates the durable power of attorney of another absent the declarant’s consent or direction or who falsifies or forges a revocation of the durable power of attorney of another shall be imprisoned for no less than six (6) months but no more than one year, or shall be fined not less than two thousand dollars (\$2,000) but no more than five thousand dollars (\$5,000).

(c) Any person who falsifies or forges the durable power of at-

torney of another, or willfully conceals or withholds personal knowledge of a revocation as provided in § 23-4.10-3 with the intent to cause a withholding or withdrawal of life sustaining procedures, shall be imprisoned for no less than one year but no more than five (5) years, or shall be fined not less than five thousand dollars (\$5,000) but no more than ten thousand dollars (\$10,000).

(d) In addition to the sanctions and/or penalties previously mentioned in this section, any physician or person referred to in this section or in violation of this section, shall be civilly liable.

Title 23 Health and Safety

Chapter 23-4.11 Rights of the Terminally Ill Act

23-4.11-1 Purpose.

(a) The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life sustaining procedures withheld or withdrawn in instances of a terminal condition.

(b) In order that the rights of patients may be respected even after they are no longer able to participate actively in decisions about themselves, the legislature declares that the laws of the state shall recognize the right of an adult person to make a written declaration instructing his or her physician or nurse practitioner to withhold or withdraw life sustaining procedures in the event of a terminal condition.

23-4.11-2 Definitions.

The following definitions govern the construction of this chapter:

(1) "Advance directive protocol" means a standardized, state-wide method developed for emergency medical services personnel by the department of health and approved by the ambulance service advisory board, of providing palliative care to, and withholding life-sustaining procedures from, a qualified patient.

(2) "Artificial feeding" means the provision of nutrition or hydration by parenteral, nasogastric, gastric or any means other than through per oral voluntary sustenance.

(3) "~~Attending physician~~" "Attending clinician" means the physician or nurse practitioner who has primary responsibility for the treatment and care of the patient.

(4) "Declaration" means a witnessed document executed in ac-

cordance with the requirements of § 23-4.11-3.

(5) "Director" means the director of health.

(6) "Emergency medical services personnel" means paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians, or other emergency services personnel acting within the ordinary course of their professions.

(7) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession.

(8) "Life sustaining procedure" means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process. "Life sustaining procedure" shall not include any medical procedure or intervention considered necessary by the attending ~~physician~~ clinician to provide comfort and care or alleviate pain.

(9) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, government, governmental subdivision or agency, or any other legal entity.

(10) "Physician" means an individual licensed to practice medicine in this state.

(11) "Nurse practitioner" means an individual licensed as a certified registered nurse practitioner pursuant to § 5-34-3.

~~(11)~~ (12) "Qualified patient" means a patient who has executed a declaration in accordance with this chapter and who has been determined by the attending physician to be in a terminal condition.

~~(12)~~ (13) "Reliable documentation" means a standardized, state-wide form of identification such as a nontransferable necklace or bracelet of uniform design, adopted by the director of health, with consultation from the local community emergency medical services agencies and licensed hospice and home health agencies, that signifies and certifies that a valid and current declaration is on file and that the individual is a qualified patient.

~~(13)~~ (14) "Terminal condition" means an incurable or irreversible condition that, without the administration of life sustaining procedures, will, in the opinion of the attending physician, result in death.

23-4.11-3 Declaration relating to use of life sustaining procedures.

(a) A competent individual eighteen (18) years of age or older may at any time execute a declaration governing the withholding or withdrawal of life sustaining procedures. The declaration must be signed by the declarant, or another at the declarant's direction in the presence of two (2) subscribing witnesses who are not related to the declarant by blood or marriage.

(b) A physician or other health care provider who is provided a copy of the declaration shall make it a part of the declarant's medical record.

(c) A declaration has operative effect only when:

(1) The declaration is communicated to the attending ~~physician~~ clinician;

(2) The declarant is determined by the attending ~~physician c-~~ linician to be in a terminal condition; and

(3) The declarant is unable to make treatment decisions.

(d) A declaration may, but need not, be in the following form:

DECLARATION

I, _____, being of sound mind willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

This authorization includes () does not include () the withholding or withdrawal of artificial feeding (check only one box above).

Signed this _____ day of _____, _____.

Signature;

Address

The declarant is personally known to me and voluntarily signed this document in my presence.

Witness Witness

Address Address

23-4.11-6 Treatment of qualified patients.

(a) A qualified patient has the right to make decisions regarding use of life sustaining procedures as long as the patient is able to do so. If a qualified patient is not able to make those decisions, the declaration governs decisions regarding use of life sustaining procedures.

(b) This chapter does not prohibit any action considered necessary by the attending ~~physician~~ clinician or comfort and care or alleviation of pain.

(c) The declaration of a qualified patient known to the attending ~~physician~~ clinician to be pregnant shall be given no force or effect as long as it is probable that the fetus could develop to the point of live birth with continued application of life sustaining procedures.

23-4.11-8 Immunities.

(a) In the absence of actual notice of the revocation of a declaration, the following, while acting in accordance with the requirements of this chapter, are not subject to civil or criminal liability or charges of unprofessional conduct:

(1) A physician or nurse practitioner who causes the withholding or withdrawal of life sustaining procedures from a qualified patient.

(2) A person who participates in the withholding or withdrawal of life sustaining procedures under the direction or with the authorization of a physician or nurse practitioner.

(3) The health care provider owning or operating the facility in which the withholding or withdrawal occurs.

(4) Emergency medical services personnel who cause or participate in the withholding or withdrawal of life-sustaining procedures under the direction of or with the authorization of a physician or nurse practitioner or who on receipt of reliable documentation follow an advance directive protocol.

(5) Emergency medical services personnel who proceed to provide life-sustaining treatment to a qualified patient pursuant to a revocation communicated to them.

(b) A physician or nurse practitioner is not subject to civil or criminal liability for actions under this chapter which are in accordance with reasonable medical standards.

23-4.11-9 Penalties.

(a) Failure of a physician or nurse practitioner to transfer a patient pursuant to § 23-4.11-7 shall constitute “unprofessional conduct” as that term is used in § 5-37-5.1.

(b) Failure of a physician or nurse practitioner to record the determination of terminal condition pursuant to § 23-4.11-5 shall constitute “unprofessional conduct” as that term is used in § 5-37-5.1.

(c) Any person who willfully conceals, cancels, defaces, or obliterates the declaration of another absent the declarant’s consent or direction or who falsifies or forges a revocation of the declaration of another shall be imprisoned for no less than six (6) months but no more than one year, or shall be fined not less than two thousand dollars (\$2,000) but no more than five thousand dollars (\$5,000).

(d) Any person who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of a revocation as provided in § 23-4.11-4 with the intent to cause a withholding or withdrawal of life sustaining procedures, shall be imprisoned for no less than one year but no more than five (5) years, or shall be fined not less than five thousand dollars (\$5,000) but no more than ten thousand dollars (\$10,000).

(e) In addition to the sanctions and/or penalties mentioned in this section, any physician or person referred to in this section or in violation of this section, shall be civilly liable.

23-4.11-14 Instructional bracelets.

(a) Upon the request of a physician or nurse practitioner, acting on behalf of a qualified patient who does not wish to be resuscitated, the department of health shall issue a nontransferable, nonremovable bracelet to a specific qualified patient, which will be marked “DNR”, meaning “do not resuscitate”. The bracelet shall also bear the name and address of the patient and the name, address, license number and signature of the physician who has ordered the bracelet to be affixed to the patient’s wrist.

(b) If it appears that the bracelet has been tampered with, or has been removed, any physician or emergency medical personnel shall not follow the instructions of the bracelet or former bracelet and may resuscitate the patient.

(c) All bracelets issued by the department of health pursuant to this section shall be registered with the fire department for the

city or town in which the patient resides.

(d) The director of the department of health is empowered and directed to promulgate reasonable rules and regulations consistent with this chapter to carry out the purposes of this section.

Title 23 Health and Safety

Chapter 23-5 Reports of Disease and Disability

23-5-9 Upon death - Report of infectious disease.

(a) As used in this section, "infectious or communicable disease" includes the following:

- (1) Infectious hepatitis;
- (2) Tuberculosis;
- (3) Rabies;
- (4) Tularemia;
- (5) Herpes simplex;
- (6) Acquired immune deficiency syndrome;
- (7) Viral hemorrhagic fever;
- (8) Gonorrhea;
- (9) Syphilis;
- (10) Burkett's lymphoma; and
- (11) Kaposi's sarcoma.

(b) Notwithstanding the provisions of §§ 40.1-5-26 and 5-37.3-4, when a person who has been diagnosed as having an infectious or communicable disease dies in a hospital or other health care facility, the attending physician, nurse practitioner, or other responsible officer shall prepare a written notification describing the disease to accompany the body when the body is picked up for disposition.

(c) Notwithstanding the provisions of §§ 40.1-5-26 and 5-37.3-4, when a person dies outside of a hospital or health care facility and without an attending physician or nurse practitioner, any family member or person making arrangements for the disposition of the dead body who knows that the dead person has been diagnosed as having an infectious or communicable disease at the time of death shall make known that disposition.

(d) Notwithstanding the provisions of §§ 40.1-5-26 and 5-37.3-4, any person who picks up or transports a dead body for disposition and who has been notified pursuant to subdivision (2) or (3) of this section shall present a notification accompanying the dead body to any embalmer, funeral director, or other person taking

possession of the dead body.

(e) Information regarding a deceased's infectious or communicable disease contained in a notification required under this section shall be privileged and confidential and may be disclosed only if the disclosure is required under state or federal laws.

(f) Any person having duties imposed upon him or her under subsection (b), (c), or (d) of this section who knowingly refuses or omits to perform those duties shall be subject to a fine of three hundred dollars (\$300) for a first offense, five hundred dollars (\$500) for a second offense, and one thousand dollars (\$1000) for a third and subsequent offense within any calendar year.

Title 23 Health and Safety

Chapter 23-5.1 Identification of Persons Suffering From Certain Disabilities

23-5.1-1 Identification bracelet.

Any person who has epilepsy, diabetes, a cardiac condition, or any other type of illness that causes temporary blackouts, semi-conscious periods, or complete unconsciousness, is authorized to wear an identification bracelet with the person's name, type of illness, physician's name or nurse practitioner's name, and medication required, engraved, stamped, or imprinted on that bracelet.

Title 23 Health and Safety

Chapter 23-6 Prevention and Suppression of Contagious Diseases

23-6-11 Definitions.

As used in §§ 23-6-10 - 23-6-24:

(1) "AIDS" means the medical condition known as acquired immune deficiency syndrome, caused by infection of an individual by the human immunodeficiency virus (HIV).

(2) "HIV" means the human immunodeficiency virus, the pathogenic organism responsible for the acquired immunodeficiency syndrome (AIDS).

(3) "Informed consent form" means a standardized form provided by the Rhode Island department of health to those individuals offered HIV testing. The form shall be developed by the department and shall contain the following information:

(i) The public health rationale for HIV testing and information describing the nature of the HIV disease;

- (ii) The availability and cost of HIV testing and counseling;
- (iii) That test results are confidential with certain exceptions;
- (iv) A list of exceptions to confidentiality of test results;
- (v) That the test is voluntary and that an informed consent form must be signed before testing;

(vi) That by signing this form the person is only acknowledging that the HIV test and counseling have been offered and/or that he or she has declined (opted-out) the offer to be tested; and

(vii) Notwithstanding the provisions of subsections (v) and (vi) above, in the event an individual consents to anonymous testing, the HIV testing counselor and/or attending practitioner ordering the test shall receive only verbal confirmation from the client that the client understands all applicable information contained within the informed consent form.

(4) "HIV test" means any currently medically accepted diagnostic test for determining infection of an individual by HIV.

(5) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, state or political subdivision or instrumentality of a state.

(6) "Physician" means a person licensed to practice allopathic or osteopathic medicine pursuant to the provisions of chapter 37 of title 5.

(7) "Nurse practitioner" means an individual licensed as a certified registered nurse practitioner pursuant to § 5-34-3.

~~(7)~~ (8) "Services" means health care and social support services.

~~(8)~~ (9) "Occupational health representative" is an individual, within a health care facility, trained to respond to occupational, particularly blood borne, exposures.

23-6-17 Confidentiality.

(a) It is unlawful for any person to disclose to a third party the results of an individual's HIV test without the prior written consent of that individual, or in the case of a minor, the minor's parent, guardian, or agent, on a form that specifically states that HIV test results may be released, except:

(1) A licensed laboratory or other health care facility which performs HIV tests shall report test results to a patient's licensed physician or other medical personnel who requested the test, and to the director of the department of health, pursuant to rules and regulations adopted for that purpose.

(2) A physician:

(i) May enter HIV test results in the medical record, as would be the case with any other diagnostic test;

(ii) May notify other health professionals directly involved in the care of the individual testing positive on the HIV test, or to whom that individual is referred for treatment;

(iii) May notify persons exposed to blood or other body fluids of an individual who tests positive for HIV, pursuant to § 23-6-14(4) through (8) (exceptions) and § 23-17-31 (testing of hospitalized patients);

(iv) May notify the director of the department of children, youth, and families, pursuant to § 23-6-14(3) (testing of a minor to secure services); and

(v) May inform third parties with whom an HIV-infected patient is in close and continuous exposure related contact, including but not limited to a spouse and/or partner, if the nature of the contact, in the physician's opinion or nurse practitioner's opinion, poses a clear and present danger of HIV transmission to the third party, and if the physician has reason to believe that the patient, despite the physician's or nurse practitioner's strong encouragement, has not and will not inform the third party that they may have been exposed to HIV;

(3) As permitted in subsections (b)(1), (2), (5), (6), (8), (9), (10), (11), (12), (13), (14), and (15) of § 5-37.3-4 (confidentiality of health care information) and § 40.1-5-26 (disclosure of confidential information under mental health law), or as otherwise required by law.

(4) By a health care provider to appropriate persons entitled to receive notification of persons with infectious or communicable diseases pursuant to §§ 23-5-9 (report of infectious disease upon death) and 23-28.36-3 (notification to EMT, firefighter, police officer of infectious disease).

(b) Facilities and other health care providers subject to this section will have documentation that each person with access to any confidential information understands and acknowledges that the information may not be disclosed except as provided herein. The director shall establish protocols for collecting, maintaining and transferring the information (and ultimately destroying the information) to ensure the integrity of the transfer, and, if possible, the director may suspend any transfer, even to CDC, if he or she is not confident that the transfer is secure.

Title 23 Health and Safety**Chapter 23-7.1 Rodent Control and Eradication****23-7.1-7 Bite report not violation of physician health care provider-patient relationship.**

Any report of rodent bites made pursuant to regulations promulgated by the director shall not be deemed a violation of the physician health care provider-patient relationship or otherwise contrary to the ethics of the medical profession.

Title 23 Health and Safety**Chapter 23-10 Report of Tubercular Cases by Institutions****23-10-2 Reports by physicians or nurse practitioners.**

Whenever any physician or nurse practitioner knows that any person under his or her professional care is affected with tuberculosis, he or she shall transmit to the director of the state department of health within seven (7) days, upon blanks provided by the state department of health for that purpose, the name, sex, age, color, race, occupation, social condition, and residence of that person. Any physician or nurse practitioner failing or refusing to comply with the requirements of this section shall be guilty of a misdemeanor and on conviction shall be subject to a fine of ten dollars (\$10.00).

Title 23 Health and Safety**Chapter 23-11 Sexually Transmitted Diseases****23-11-6 Reports by physicians or nurse practitioners.**

Any physician or nurse practitioner who diagnoses and/or treats a case of sexually transmitted disease shall immediately make a report of that case to the state department of health in the manner and form that the department shall direct.

23-11-15 Report not violation of physician health care provider-patient relationship.

Any report made pursuant to the provisions of this chapter shall not be deemed a violation of the physician health care provider-patient relationship or otherwise contrary to the ethics of the medical profession.

Title 23 Health and Safety

Chapter 23-17 Health Care Quality Program

23-17-10.5 Medical director and attending physician or nurse practitioner file.

Each nursing facility licensed under this chapter shall designate a physician to serve as medical director. The medical director shall be responsible for implementation of resident care policies and for the coordination of medical care in the facility. Such responsibilities shall include, but not be limited to: the implementation of facility policies and procedures related to the medical care delivered in the facility; physician and advanced practice practitioner credentialing; practitioner performance reviews; employee health including infection control measures; evaluation of health care delivery, including oversight of medical records and participation in quality improvement; provision of staff education on medical issues; participation in state survey process, including the resolution of deficiencies as needed; and such other duties and responsibilities as may be stipulated in regulations promulgated by the department of health.

The medical director, charged with the aforementioned duties and responsibilities for the delivery of medical care in the nursing facility, shall be immune from civil or criminal prosecution for reporting to the board of medical licensure and discipline the unprofessional conduct, incompetence or negligence of a nursing facility physician or limited registrant; provided, that the report, testimony or other communication was made in good faith and while acting within the scope of authority conferred by this section. Each nursing facility shall maintain an active file of all current attending physicians or nurse practitioners including their phone number and address, an emergency phone number, their current medical license number, and their preferred hospital admitting privileges. The director of the department of health is hereby authorized to promulgate rules and regulations to implement the provisions of this section.

Title 23 Health and Safety

Chapter 23-17.5 Rights of Nursing Home Patients

23-17.5-6 Care by physician or nurse practitioner - Disclosure of patient's medical condition.

(a) Each patient admitted to a facility shall be and remain

under the care of a physician as specified in policies adopted by the governing body.

(b) Each patient shall be informed by a physician or nurse practitioner of his or her medical condition unless medically contraindicated, as documented by a physician or nurse practitioner in his or her medical record, and shall be afforded the opportunity to participate in the planning of his or her medical treatment.

Title 23 Health and Safety

Chapter 23-17.18 Health Plan Modification Act

23-17.18-1 Modification of health plans.

(a) A health plan may materially modify the terms of a participating agreement it maintains with a physician only if the plan disseminates in writing by mail to the physician the contents of the proposed modification and an explanation, in nontechnical terms, of the modification's impact.

(b) The health plan shall provide the physician an opportunity to amend or terminate the physician contract with the health plan within sixty (60) days of receipt of the notice of modification. Any termination of a physician contract made pursuant to this section shall be effective fifteen (15) calendar days from the mailing of the notice of termination in writing by mail to the health plan. The termination shall not affect the method of payment or reduce the amount of reimbursement to the physician by the health plan for any patient in active treatment for an acute medical condition at the time the patient's physician terminates his, her, or its physician contract with the health plan until the active treatment is concluded or, if earlier, one year after the termination; and, with respect to the patient, during the active treatment period the physician shall be subject to all the terms and conditions of the terminated physician contract, including but not limited to, all reimbursement provisions which limit the patient's liability.

(c) Subsections (a) and (b) of this section shall apply to a physician or a nurse practitioner.

(e) (d) Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

Title 23 Health and Safety

Chapter 23-24.6 Lead Poisoning Prevention Act

23-24.6-7 Screening by health care providers.

(a) The department shall promulgate regulations establishing the means by which and the intervals at which children under six (6) years of age shall be screened for lead poisoning. The department is also authorized to require screening for lead poisoning in other high risk groups.

(b) Each physician or nurse practitioner registered or licensed by Rhode Island or any agency of Rhode Island shall screen children under six (6) years of age for lead poisoning at the intervals and using the methods specified in the regulations adopted pursuant to subsection (a). Each licensed, registered or approved health care facility serving children under six (6) years of age, including but not limited to hospitals, clinics, and health maintenance organizations, shall take appropriate steps to ensure that their patients receive screening for lead poisoning at the intervals and using the methods specified in these regulations.

(c) All health care programs funded in whole or in part with state money and having child health components shall include, require, and/or provide for screening children under six (6) years of age for lead poisoning at the intervals and using the methods specified in the regulations promulgated under this section.

(d) The provisions of this section shall not apply if the parents of the child object to the child undergoing blood lead screening on the grounds that the screening conflicts with their religious tenets and practices.

(e) All blood samples taken by physicians or other health care providers licensed in Rhode Island or by licensed, registered, or approved health care facilities in Rhode Island from children under the age of six (6) years for the purpose of screening for blood lead level shall be sent to the state laboratory in the department of health for laboratory analysis.

(f) The department shall, at least annually, analyze and summarize all of the lead screening information provided by physicians, health care facilities, and laboratories and provide this information to all other local and state agencies involved with case management and lead hazard reduction. An analysis and summary of the data shall also be made available, at least annually, to the health care community, to the general assembly, and the gen-

eral public in a format that is easily understandable to non-technical readers.

23-24.6-11. Reporting of cases of lead poisoning. — Any physician or nurse practitioner registered or licensed by Rhode Island or any agency of Rhode Island or any employee of a licensed, registered, or approved health care facility making the diagnosis of childhood lead poisoning shall report that diagnosis to the director within ten (10) business days of the diagnosis.