The Shadow Health Care System: Regulation of Alternative Health Care Providers

Lori B. Andrews, Chicago-Kent College of Law

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ARTICLE

THE SHADOW HEALTH CARE SYSTEM: REGULATION OF ALTERNATIVE HEALTH CARE PROVIDERS

Lori B. Andrews*

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When policymakers think of health care providers, they generally think of physicians, nurses, and hospitals.1 When

* Professor of Law and Norman and Edna Freehling Scholar, Chicago-Kent College of Law; Research Fellow, American Bar Foundation; B.A., Yale College, 1975; J.D., Yale Law School, 1978. The author would like to thank Nanette Elster, Charles Inlander, Lowell Levin, Patricia Stevenson, and Marsden Wagner.

1. See, e.g., Edward S. Sekscenski et al., State Practice Environments and the Supply of Physician Assistants, Nurse Practitioners, and Certified Nurse-Midwives, 331 NEW ENG. J. MED. 1266, 1266 (1994) (stating that “[m]ost proposals to increase
consumers think of health care providers, however, their list is much longer. They seek preventive, diagnostic, and therapeutic health care services from dozens of different types of providers in alternative settings that are rarely studied by academics and poorly understood by regulators.2 Rather than representing a tiny adjunct to traditional health care, the services of alternative providers represent a major and growing proportion of health care as a whole. A study published in the New England Journal of Medicine found that in 1990, 425 million Americans consulted alternative providers, while only 388 million consulted primary care physicians.3 A May 1995 poll in the San Francisco Bay Area found that while 31% of respondents had seen a physician in the past year, 41% had tried alternative treatments such as chiropractic, acupuncture, and biofeedback.4 The gap was even more striking among people of higher income levels. Of respondents who earned more than $60,000 per year, 26% had seen a doctor in the past year while 43% had tried alternative treatments.5

Because of consumer demand, the ranks of alternative practitioners are growing. There are now approximately 27,226 nurse practitioners,6 and the number of nurse midwives has doubled in each decade since the 1950s.7 In 1991, certified nurse midwives attended 167,704 births—eight times the number in 1975.8 The first physician assistant program opened in 1961 at Duke University School of Medicine; there were fifty-eight such programs by 1993.9 It is predicted that there will be 42,000 practicing physician assistants by the year 2000.10

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3. See id. at 250.
5. Id. at A12.
8. Fran O'Connell, New Age Healers Need Producers' Care, BEST'S REV.—PROPS./CASMALTY INS. EDITION, Sept. 1994, at 72, 72 (citing data from the National Center for Health Statistics).
9. See Jones & Cawley, supra note 6, at 1266.
10. Kathleen Doheny, Physician Assistant: A New Hot Job, L.A. TIMES, June 5,
There is now even a variety of scientific journals dealing with alternative medicine, including the Journal of Alternative and Complementary Medicine: Research on Paradigm, Practice, and Policy; Alternative Therapies in Health and Medicine; and Alternative Health Practitioner: The Journal of Complementary and Natural Care. 11 In 1992, the National Institutes of Health created the Office of Alternative Medicine (OAM) to fund research on alternative therapies. 12 Some of the studies underway analyze the use of acupuncture for depression and relaxation techniques for breast cancer. 13

This Article analyzes why people seek services from alternative providers, how such services compare to those provided by physicians, what legal barriers impede greater use of alternative providers, and how legal policies might be revamped in order to reap the benefits that alternative providers offer.

For purposes of illustration, I will give examples involving physician assistants, podiatrists, chiropractors, and advanced practice nurses, including midwives and nurse anesthetists. However, it should be noted that over 125 recognized categories of health care providers exist. 14 For example, the State of California licenses, certifies, or registers individuals in thirty-two health professions and occupations. 15

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11. See Leslie Miller, Alternatives Go on the Record: Medical Journals Follow Growing Field, USA TODAY, Jan. 12, 1995, at 6D.
12. See Dan Wascoe, Alternative Remedies: Insurers Wary of Trend Toward Natural Medicine, STAR-TRIBUNE, Sept. 12, 1994, at 1A (recounting that the OAM was created in response to a congressional order to study alternative health care). In September 1994, the OAM awarded its first 30 research grants. Id. The grants awarded illustrate the broad range of alternative health care methods: massage therapy for people infected with HIV; hypnosis for chronic low back pain and accelerated healing of broken bones; acupuncture for depression and hyperactivity; prayer intervention for substance abuse; electrochemical treatment for tumors; biofeedback for diabetes and back and facial pain; and herbal substances for Parkinson's disease.

Id.
13. See Robin Herman, Therapies Outside the Mainstream, WASH. POST, Aug. 1, 1995 (Magazine), at 10, 14. Currently, the OAM has funded 90 alternative medicine studies totaling $13 million. Id.
15. California regulates the following health care professionals: chiropractors, CAL. BUS. & PROF. CODE §§ 1000-1002 (West 1990); clinical laboratory technicians, id. §§ 1200-1327 (West 1990 & Supp. 1995); dentists, id. §§ 1625-1636.5; pediatric medicine, id. §§ 2460-2499.8; drugless practitioners, id. §§ 2500-2504; licensed midwives, id. §§ 2505-2521 (West Supp. 1995); research psychoanalysts, id. § 2529 (West 1990); speech-language pathologists and audiologists, id. §§ 2530-2536 (West Supp. 1995); registered dispensing opticians, id. §§ 2550-2569 (West 1990 & Supp. 1995);
I. THE APPEAL OF ALTERNATIVE PROVIDERS

Consumers seek services from alternative providers rather than physicians for a variety of reasons, including greater accessibility, lower cost, and the possibility for service that is more in keeping with the consumer's personal desires, cultural beliefs, or health care needs. With respect to accessibility, there is a documented need for more health care providers in poor rural areas. The public policy initiatives of scholarship and loan repayment programs used to prompt physicians to fill that need by requiring physicians to work in underserved areas have not had the desired long-term impact of encouraging providers to stay in those locations or practice there after their initial obligation has been met. Consequently, alternative providers can play a large role in meeting the needs of underserved populations. For example,

occupational therapists, id. § 2570; dietitians, id. §§ 2585-2586 (West 1990); perfusionists, id. §§ 2590-2596 (West Supp. 1995); physical therapists, id. §§ 2630-2639 (West 1990 & Supp. 1995); physical therapist assistants, id. §§ 2655-2655.11; nurse-midwives, id. §§ 2746-2746.8; nurse-anesthetists, id. §§ 2825-2833.6; nurse-practitioners, id. §§ 2834-2837; vocational nurses, id. §§ 2840-2895.1; psychologists, id. §§ 2900-2995; hearing aid dispensers, id. §§ 3350-3456; physician assistants, id. §§ 3500.5-3503; osteopathic physician assistants, id. § 3535; osteopathic medicine, id. §§ 3600 to 3600-5; respiratory therapists, id. §§ 3700-3777; nursing home administrators, id. §§ 3901-3950; pharmacy, id. §§ 4000-4438; medical device retailers, id. § 4131; psychiatric technicians, id. §§ 4500-4548; veterinary medicine, id. §§ 4800-4910; acupuncturists, id. §§ 4925-4975; marriage, family, and child counselors, id. §§ 4980-4989; social workers, id. §§ 4990-4998.7.

16. See Office of Technology Assessment, U.S. Congress, Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis 34 (1986) [hereinafter OTA Study] (concluding that access to care is limited geographically in inner-cities and nongeographically for groups such as the elderly).

17. See O'Connell, supra note 8, at 72 (noting that some patients sought alternative practitioners “to sidestep the high-tech, high-priced medical industry”).


20. See Herman, supra note 13, at 10 (reporting Georgetown psychiatry professor James Gordon’s theory that those who “simply do not feel good” and those “who have come to the limits of traditional Western medicine for chronic illness or life-threatening conditions” seek alternative care).


22. See id. at 37, 46.
certified nurse midwives significantly improve access in underserved areas such as the rural south, inner cities, and reservations of Native Americans. 23 Similarly, approximately one-third of physician assistants work in rural areas, 24 and nurse anesthetists are the sole providers of anesthesia services in thirty-five percent of hospitals, with eighty-five percent of these hospitals in rural areas. 25

Even outside of underserved areas, the use of alternative providers can enhance access because of their potential to provide primary care 26 and chronic disease care. 27 Advanced nurse practitioners, for example, may be in a better position than physicians to provide primary care because nursing schools focus on disease prevention and a holistic approach to health while medical schools rely on sophisticated technology in specialized settings. 28 A study by the Office of Technology Assessment of the U.S. Congress concluded that nurse practitioners “have helped improve geographic access to primary care.” 29 Moreover, physicians as a whole have become too specialized to deal with primary care problems. Three-quarters of physicians are specialists. 30 Of 1992 medical graduates, only 14.2% were planning to work in primary care, as compared with 37.3% in 1981. 31

24. See Sekscenski et al., supra note 1, at 1266 ("About 34 percent of physician assistants [in 1992] worked in rural areas.").
26. See OTA STUDY, supra note 16, at 34 (explaining that alternative providers such as nurse practitioners and physician assistants “have long been recognized for increasing geographic access to primary health care”).
27. See, e.g., Herman, supra note 13, at 10 (noting that many chronically ill individuals, such as cancer patients and individuals who are HIV-positive, seek alternative care).
28. See Aiken & Sage, supra note 25, at 196.
31. Id. The overspecialization of physicians has led to various calls for policy reform. A recent article in the New England Journal of Medicine reports that there will be an excess of 165,000 specialist physicians in the year 2000 and proposes a policy that will limit the number of graduates of foreign medical schools who enter residency programs each year. Michael E. Whitcomb, Correcting the Oversupply of Specialists by Limiting Residencies for Graduates of Foreign Medical Schools, 333 New Eng. J. Med. 454, 454 (1995). Other policy proposals for specifically targeting and rewarding medical students with an affinity for delivering care to the underserved are discussed in Scammon et al., supra note 21, which notes, “There is no denying that there is an increasing demand for primary care providers, particularly those who are willing and trained to be successful in practice in underserved settings; and medical schools are not graduating sufficient numbers of generalists to meet this demand.” Id. at 46.
Alternative providers can also serve the needs of people with chronic diseases, such as coronary artery disease and stroke, who make up a large proportion of the patient population.\(^{32}\) The proper health management of chronic illness requires attention to prevention before the disease occurs\(^{33}\) and coping with chronic disease after it occurs.\(^{34}\) Many of these teaching, monitoring, and self-treatment functions can be performed by individuals who do not have a medical license.\(^{35}\) Moreover, evidence suggests that licensed medical doctors are not particularly adept at meeting the needs of chronically ill people. With their super specialization, doctors are overqualified or misqualified for the treatment of routine health problems, or they may find the treatment of routine problems boring.\(^{36}\)

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32. See Public Health Serv., U.S. Dep't Health & Human Servs., Healthy People 2000: National Health Promotion and Disease Prevention Objectives 3 (1992) [hereinafter Healthy People].

33. Prevention is important because lifestyle, major life events, and the ability to cope with these as well as physical environmental factors have a proven correlation with chronic disease, particularly with the most common health threats of heart disease, cancer, and stroke. See John H. Knowles, The Responsibility of the Individual, 106 Daedalus 57, 61-64 (1977); see also Suzanne G. Haynes et al., The Relationship of Psychosocial Factors to Coronary Heart Disease in the Framingham Study, 111 Am. J. Epidemiology 37, 38 (1980) (suggesting that certain behaviors and life styles may cause the development of coronary heart disease); William B. Kannel, Meaning of the Downward Trend in Cardiovascular Mortality, 247 JAMA 877, 877 (1982) (attributing the decline in deaths from coronary heart disease in part to preventive measures and changes in lifestyle). The need for a greater emphasis on prevention is increasingly being recognized in the policy sphere. See, e.g., Healthy People, supra note 32, at 1 (outlining a strategy for improving the nation's health that relies heavily on disease and disability prevention).

34. See Lori B. Andrews & Lowell S. Levin, Self-Care and the Law, Soc. Pol'y, Jan.-Feb. 1979, at 44, 45 (noting that those with chronic diseases such as diabetes must learn particular health routines regarding diet and medication).

35. See id. (explaining that up to 75% of all health care could be administered through self-care).


In response to the question, "Would you rather deal with an acutely ill patient or one who is chronically or terminally ill?" the majority of students unhesitatingly chose the acutely ill patient (76.3% during the freshman year, 72.0% during the sophomore year, 75.0% during the junior year, and 81.8% during the final year).

Id. at 159 n.". Apparently, such patients can require much of the physician's time and do not offer the satisfying opportunity for physicians to perform a cure. See id. at 159 (quoting students who find caring for chronically ill patients "gets boring because you're not learning anything from them" and "[i]t's more fun being where the action is"). In addition, doctors are not very good at caring for people with chronic diseases because of the discrepancy between the goals of current medical education as grounded in a technologically oriented approach and the larger needs of chronically ill persons. See generally Anselm Strauss, A Sociologist's Perspective, in Humanizing
The use of alternative providers can result in cost savings as well. Nonphysician providers charge less for their services because they have much lower training costs and receive much lower salaries. Primary care physicians earn about four times as much as nurse practitioners, and obstetricians earn about ten times as much as certified nurse midwives. Studies show that chiropractor services are more cost-effective than those of physicians for particular problems.

Some traditional third-party payors are beginning to explore reimbursement for alternative types of care. In the summer of 1993, Mutual of Omaha agreed to reimburse plan participants who enrolled in a nontraditional therapy program for coronary disease, focusing on diet, exercise, and stress management. Mutual of Omaha, reporting savings of $6.50 for every dollar spent since adopting that plan, has led other major insurers including Travelers and Blue Cross Blue Shield to extend similar coverage.

Some insurers have noticed the savings that can result from a home birth attended by a licensed midwife rather than hospital delivery for low-risk births. In Arizona, for example, the average hospital delivery including doctor's fees is approximately $5100, as compared to $1400 for prenatal care and home birth with a licensed midwife. Such potential savings have led to reimbursement by several insurers such as Mutual of Omaha, Prudential, and Blue Cross Blue Shield.

While the cost savings of alternative providers is attractive

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37. See, e.g., Barbara J. Safriet, Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing, 9 Yale J. on Reg. 417, 437 (1992) (commenting on studies showing that the direct cost of educating a doctor is five times that of educating a nurse practitioner).

38. For example, physician assistants made an average of $53,500 in 1993, as compared to $189,300 for physicians. Compare Jones & Cavley, supra note 6, at 1268 (physician assistants) with David Burda, After Hesitating, AMA Releases Data Showing 7% Rise in Docs' Pay, Modern Healthcare, Dec. 19, 1994, at 28, 28 (physicians).

39. See Safriet, supra note 37, at 438 & n.90. The average income of certified nurse midwives in 1986 was $30,000 while obstetricians made $296,000. Id. at 438 n.90.

40. See Rebecca Berg, Note, HMO Exclusion of Chiropractors, 66 S. Cal. L. Rev. 807, 833-34 (1993) (discussing data analyzing the cost of chiropractic care and noting that “the conclusion that chiropractor-provided services are less costly than physician-provided services is sound”).


42. See id.


44. See Tippit, supra note 41.
to some patients, many other people are willing to consult nonphysicians even when it is more costly, as when third-party payors refuse to reimburse their care. According to one study, people spent $13.7 billion in 1990 on alternative providers such as chiropractors and acupuncturists, with $10.3 billion in out-of-pocket costs.\footnote{Eisenberg et al., supra note 2, at 246.}

Beyond these issues of access and cost, patients may be rejecting traditional medical care\footnote{A recent New York Times Magazine article on alternative medicine notes that the "enormous interest seems to be based on the perception that mainstream medicine has become more enamored of fancy machines than of the art of healing and on the inability of scientific medicine to cope with the scourges of the times: heart disease, cancer, AIDS." Chip Brown, The Experiments of Dr. Oz, N.Y. TIMES MAGAZINE, July 30, 1995, at 21, 22.} due to distrust of conventional medical treatments or a desire for more holistic care, or they may be affirmatively choosing alternative providers because they perceive them to offer better quality with greater sensitivity and better communication. Alternative providers may also be seen as giving patients greater control over the most intimate and important experiences of their lives, such as giving birth with midwives or dying with hospice care. In one study, for example, none of the patients assisted by a nurse midwife during delivery would have preferred a physician-assisted delivery, but some of the obstetrician’s patients would have preferred assistance from a midwife.\footnote{See OTA STUDY, supra note 16, at 24.} Another survey found that twice as many people were dissatisfied with the care they received from physicians than were dissatisfied with the care they received from alternative providers.\footnote{See Russell, supra note 4, at A1 ("Seven percent of those who had tried alternative medicine were dissatisfied with the experience; twice as many were unhappy with their treatment by doctors.").}

Abundant data exists supporting the conclusion that alternative providers are more user-friendly. On the issue of communication, consumers are more satisfied with nurse practitioners than physicians regarding the amount of information conveyed.\footnote{OTA STUDY, supra note 16, at 19.} Moreover, the emphasis on communication can often lead to better treatment. For example, in a study in which a random sample of 501 physicians and 298 nurse practitioners was surveyed and asked questions about a hypothetical patient, “If more nurses than physicians elicited the basic historical information necessary to make an intelligent treatment plan for the patients presented.”\footnote{Jerry Avorn et al., The Neglected Medical History and Therapeutic Choices for Abdominal Pain: A Nationwide Survey of 799 Physicians and Nurses, 151 AR-}
Alternative providers may also have greater ethnic and cultural sensitivity to minority group patients and female patients. While medicine is mainly a white male profession, alternative practitioners such as physician assistants compose a higher proportion of women and minorities, potentially creating greater empathy for female patients and patients of color. As Linda Aiken and William Sage point out, "Because minority practitioners are more likely than other professionals to serve minority patients, a more diverse workforce can improve the availability of services in underserved areas, overcome institutional prejudices that discriminate against minority patients and provide more culturally sensitive care."

Consumer satisfaction with alternative providers is demonstrated in a number of ways. There are few complaints to state disciplinary boards about alternative providers. Alternative providers also have fewer malpractice cases brought against them than physicians. While eighty-five percent of obstetricians


51. Vast amounts of literature by feminists and others criticizing the treatment that female patients receive from male physicians exist. See, e.g., SUZANNE ARMS, IMMACULATE DECEPTION: A NEW LOOK AT WOMEN AND CHILDBIRTH IN AMERICA (1975); ROBERT S. MENDELSOHN, MALE PRACTICE: HOW DOCTORS MANIPULATE WOMEN (1981); MISDIAGNOSIS: WOMAN AS A DISEASE (Karen M. Hicks ed., 1994). For example, birth centers are increasing in popularity because of dissatisfaction with the cold, medicalized treatment of birth in hospitals. See, e.g., Bergman, supra note 18, at 46 (reporting the story of one woman who rejected traditional birth because "she was turned off by the stark fluorescent lights and white linoleum floors . . . [and] the cold manner of the obstetrician and nurse she met"). For information about how women's health needs have been ignored in the research setting, see Karen H. Rothenberg, GENDER MATTERS: IMPLICATIONS FOR CLINICAL RESEARCH AND WOMEN'S HEALTH CARE, 32 HOU. L. REV. 1201 (1996).

52. See Aiken & Sage, supra note 25, at 190 (reporting that minorities comprise 7% of doctors, even though they represent 22% of the population).

53. In 1992, 10% of students in master's degree nursing programs were minorities. Id. at 198 n.59. Women comprise 60% of those enrolled in physician assistant programs, with minorities comprising 20%. Jones & Cawley, supra note 6, at 1283. Minority providers increase access to care for underserved populations. Nonwhite physicians, for example, are more likely to care for minority, medically indigent, and sicker patients. See Ernest Mooy & Barbara A. Bartman, Physician Race and Care of Minority and Medically Indigent Patients, 273 JAMA 1515, 1517 (1995).

54. Aiken & Sage, supra note 25, at 190-91. It has been suggested that "lack of common language and culture, mutual respect, and shared personal knowledge can lead to unsatisfactory patient-physician interaction." Karl F. Weyrauch, Letters: Malpractice, Patient-Satisfaction, and Physician-Patient Communication, 274 JAMA 22, 122 (1995). In fact, it has been proposed that medical school curricula include education about cultural and biological diversity. See generally Oguntunji, supra note 19.

55. For example, the executive secretary of the North Carolina Board of Medical Examiners notes that the Board logs fewer than 10 complaints a year against the approximately 1900 alternative providers it licenses. Edward Martin, 'Midlevel Providers' Assume Bigger Role in Care, BUS. J. CHARLOTTE, May 15, 1995, § 1 at 25.
have been named in malpractice suits, fewer than eight percent of nurse midwives have. The lower incidence of malpractice suits and complaints against alternative providers is undoubtedly influenced by a variety of factors. It may be in part because they see healthier patients and do less potentially risky interventions. However, the quality of alternative providers and their better communication skills also undoubtedly play a role. Various studies have found a relationship between the quality of provider-patient communications and the incidence of malpractice suits.

In many instances, the alternative providers engage in practices that are at least as time-tested as those of physicians. These include nurse midwives whose services to women in labor predate those of obstetricians, and nurse anesthetists who predate physician anesthetists by more than 100 years. Moreover, as Aiken and Sage note, “the training process for American advanced practice nurses is roughly equivalent in length and similar in content to that for generalist physicians in much of Europe.” They argue that since “health indicators in many European countries are better than those in the U.S.,” there is reason to believe that expanded use of alternative providers makes policy sense. While physicians no longer make house calls, nurses and other alternative providers do. Nurses, for example, can safely and cost-effectively treat serious bacterial infections with intravenous antibiotic therapy at home. As one reporter has pointed out, nurse

56. Aiken & Sage, supra note 25, at 195.
57. See OTA STUDY, supra note 16, at 24 (noting that the disparity in malpractice statistics may be due in part to nurse midwives sending complicated or high-risk cases to physicians).
58. See, e.g., Dennis H. Novack et al., Medical Interviewing and Interpersonal Skills Teaching in US Medical Schools, 269 JAMA 2101, 2101 (1993) (“[M]alpractice suits are strongly related to physicians’ interpersonal skills . . . .” (footnotes omitted)); Ted Peskin et al., Letters: Malpractice, Patient Satisfaction and Physician-Patient Communication, 274 JAMA 22, 22 (1995) (commenting that interpersonal aspects such as physician-patient communication “are the most important predictors of patient satisfaction and consequent likelihood to institute a malpractice action”).
59. See Diers, supra note 7, at 268 (“Midwifery is the oldest health profession in history . . . .”).
60. Aiken & Sage, supra note 25, at 194.
61. Id. at 197.
62. Id.
63. See M. Lindsay Grayson et al., Home Intravenous Antibiotic Therapy: A Safe and Effective Alternative to Inpatient Care, 162 MED. J. AUSTL. 249, 263 (1995). This approach was preferred by patients. “All patients reported a strong preference for home intravenous therapy over inpatient therapy, with many describing a sense of improved self-esteem, ‘ownership’ of their illness and involvement in therapy.” Id. at 252.
practitioners "are, in a sense, the family doctors of yester-year."\textsuperscript{64}

II. THE QUALITY OF SERVICES OF ALTERNATIVE PROVIDERS

In trying to develop sound legal policies to regulate alternative providers, there is a legitimate concern that consumers not be misled into using inappropriate alternatives. Therefore, a key policy question regarding alternative practitioners is whether they can deliver quality care within their scope of practice. An impressive body of studies has found that alternative providers can safely perform many health care tasks that they are currently prohibited from performing by state laws, that many tasks currently undertaken by physicians can be performed effectively by alternative providers, and that alternative providers can offer higher quality services than physicians in certain circumstances.

Studies comparing doctors and nurse practitioners generally conclude that "nurse practitioners are at least as capable as physicians in performing many primary care functions."\textsuperscript{65} Research has found that nurse practitioners can substitute adequately for medical residents in hospitals.\textsuperscript{66} Similarly, research on physician assistants has found that they provide care "[w]ithin their areas of competence . . . indistinguishable in quality from care provided by physicians"\textsuperscript{67} and of a quality that has consistently been shown to be equivalent to physician...
Results of studies of nurse midwives are similar. Nurse midwives perform as well as physicians when assessed according to fetal, prenatal, perinatal, and maternal mortality rates. In fact, nurse midwives do better than physicians on low-risk pregnancies. Moreover, in a study in which midwives treated high-risk patients (low income, uninsured, or underinsured women) who presented a "greater risk for obstetric complications because of the relative nutritional and psychosocial deprivation of poverty," the patients had equally good outcomes as the lower risk patients seen by obstetricians.

Studies find that nurse practitioners score higher than physicians in areas such as continuity of care and emphasis on prevention, amount of advice offered and amount of time

68. James F. Cawley et al., The Future for Physician Assistants, 98 ANNALS INTERNAL MED. 993, 995 (1983); see also OTA STUDY, supra note 16, at 22 ("Within the limits of their expertise, [physician assistants] provide care that is equivalent in quality to the care provided by physicians."); Sekscenski et al., supra note 1, at 1266 ("Within their areas of competency, and with appropriate training and supervision, these practitioners [physician assistants, nurse practitioners, and certified nurse midwives] may provide medical care similar in quality to that of physicians and at less cost.").

69. See, e.g., William J. Hueston & Mary Rudy, A Comparison of Labor and Delivery Management Between Nurse Midwives and Family Physicians, 37 J. FAM. PRAC. 449, 449, 453 (1993) (finding that nurse midwives and family physicians achieve similar but not identical results in labor and delivery).

70. See OTA STUDY, supra note 16, at 23. A recent study compared Washington State home births attended by licensed midwives with hospital births attended by physicians and midwives (eliminating high-risk patients) and found that the outcomes were essentially equal, except that physician-attended births had a higher incidence of low birth weight babies. See The Nocebo Effect of Prenatal Care, MOTHERING, June 22, 1995, at 25, 25; see also Diers, supra note 7, at 279-82 (reviewing several studies and concluding that nurse midwifery produces care equivalent to traditional obstetrics).

71. See OTA STUDY, supra note 16, at 23 (finding that certified nurse midwives "can manage normal pregnancies safely and can manage them as well as, if not better than, physicians"); Judith P. Rooks et al., Outcomes of Care in Birth Centers: The National Birth Center Study, 321 N. ENG. J. MED. 1804, 1810 (1989) (concluding that birth centers can identify low-risk pregnancies and care for them in a manner that provides "lower cost, greater availability, and a high degree of satisfaction with a comparable degree of safety").


73. Id. at 1868. The majority of the obstetrician's patients were white (62.4%) and the majority of the patients attended by midwives were hispanic and black (68.5%). Id. at 1865. In addition, the midwives treated patients who had late entry into prenatal care (37.7%) and were substance abusers (10.3%). Id. at 1865-66.

74. See Alice N. Bessman, Comparison of Medical Care in Nurse Clinician and Physician Clinics in Medical School Affiliated Hospitals, 27 J. CHRONIC DISEASES
spent listening to patients,⁷⁶ and communication skills and support.⁷⁶ Due to the quality of the interaction, patients of nurse practitioners rank higher on knowledge about appropriate exercise and activities than patients of physicians.⁷⁷

There is also data suggesting that alternative providers use fewer unnecessary services. They order fewer costly tests, prescribe fewer drugs, and use lower cost treatments.⁷⁸ The studies of nurse midwives underscore this point. When midwives and physicians care for similar patients, the midwives’ patients are able to do just as well as the physicians’ patients with fewer drugs and fewer cesarean sections.⁷⁹ This suggests that physicians use these interventions when they are not needed.⁸⁰

The fact that the patients of physician assistants and advanced practice nurses fare as well as those of physicians indicates that these alternative providers accurately perceive the limits of their abilities and refer complicated patients to physicians. This is understandable because a large part of the


75. See Charles E. Lewis & Lawrence S. Linn, The Content of Care Provided by Family Nurse Practitioners, 2 J. COMMUNITY HEALTH 259, 266 (1977) (citing one study where the nurse practitioners “spent almost twice as much time with patients as the physicians did, more often employing certain nursing functions, such as counseling or therapeutic listening”).

76. Howard Foye et al., Content and Emphasis of Well-Child Visits, 131 AM. J. DISEASES CHILDREN 794, 796 (1977) (concluding, in a study focused on well-child visits, that the nurse practitioners “obtained more descriptive information and provided more directives than did the physicians”); Lewis & Linn, supra note 75, at 266 (emphasizing that nurses spend more time than physicians listening to and counseling patients).

77. See Beverly C. Flynn, The Effectiveness of Nurse Clinicians’ Service Delivery, 64 AM. J. PUB. HEALTH 604, 610 (1974) (concluding that “significantly more of the patients cared for by the nurse clinicians than the controls reported that they had been told to follow special exercises or activities and reported utilizing other medical care”).


79. See id. at xiv-xv (finding that nurse midwives use less technology and prescribe fewer drugs than doctors); Blanchette, supra note 72, at 1866 (concluding that nurse midwives performed about half as many cesarean sections (13.1%) as the physicians (26.4%)). At Prentice Women’s Hospital in Chicago, 8.5% of midwifery clients had a cesarean as opposed to 12.9% of obstetrical clients. See The Placebo Effect of Prenatal Care, supra note 70, at 25.

80. See Hueston & Rudy, supra note 69, at 453 (suggested that physicians have a higher rate of cesarean sections primarily because of the discretionary diagnosis of “failure to progress in labor”).
training of alternative providers such as nurse midwives, advanced practice nurses, and physician extenders is “recognizing what’s normal and what’s not.”

For example, nurse midwives recognize deviations from normal pregnancy and childbirth that require the aid of a medical doctor and they seek medical consultation promptly. Moreover, alternative providers know that they will face tort actions if they fail to consult physicians when necessary.

It is very important to focus on the results of these studies, which demonstrate the quality of alternative providers. Organized medicine claims that its opposition to alternative providers is based on concerns about quality, but the evidence suggests such claims are unsubstantiated. Physicians themselves admit they could safely delegate more tasks to nurse practitioners than they currently do. In addition, physicians have used alternatives such as nurse practitioners and physician assistants to lower their own cost of doing business, but have not passed the savings on to the patient. Ironically, alternative practitioners are allowed to provide care for high-risk urban poor and rural patients, and often they are the only

81. Martin, supra note 55, at 25.
82. This study was reported in EMRIKA PADUS, THE WOMAN’S ENCYCLOPEDIA OF HEALTH AND NATURAL HEALING 261 (1981); see also Janet Ungless, A Nurse-Midwife Neuer Works Alone, NEWSDAY, Mar. 27, 1995, at A26 (interview of nurse midwife Barbara Lee Sellars) (“[W]e’ve been taught from the onset of our education to be vigilant and consult or report appropriately.”).
83. See Safriet, supra note 37, at 451 (describing the ethical and legal duty of advanced practice nurses to consult with physicians when a situation is outside the boundary of their competence).
84. For example, the American Medical Association claimed that it was boycotting chiropractors because of their poor quality, but did not produce reasonable evidence to support that claim. See Wilk v. American Medical Ass’n, 895 F.2d 352, 362-64 (7th Cir.) (affirming the district court’s conclusion that the AMA’s claim of concern for patient care in boycotting chiropractors was “objectively unreasonable”), cert. denied, 496 U.S. 927, and cert. denied, 498 U.S. 982 (1990). Similarly, physicians raise issues about the safety of midwifery. See Diane Korte, Midwives on Trial, MOTHERING, Fall 1995, at 52, 55.
85. See OTA STUDY, supra note 16, at 43 (“A recent study . . . found that physicians did not delegate as many tasks as they thought [nurse practitioners] and [physician assistants] could handle safely.”).
86. See Lauren LeRoy, The Cost-Effectiveness of Nurse Practitioners, in NURSING IN THE 1980S, supra note 7, at 295, 305-06 (reporting that according to a GAO survey, most physicians who hire nurse practitioners do not pass the savings on to the patients because “[t]here is no incentive for physicians to do so”). The refusal of doctors to pass on cost savings to patients is not unique to this situation. When new, complicated, and risky procedures are introduced, they are costly to the consumer. Yet even once the procedures become simplified, routine, and quicker to perform, the price is not lowered. See PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 386 (1982) (reporting that “prices have typically remained high even when the procedures have been simplified”).
providers in such areas because many physicians do not find work in these areas or with these populations to be desirable.\textsuperscript{87} Physicians, though, when competing with alternative providers in more desirable locales and with general healthier (and wealthier) suburban patients, assert concerns about the safety of alternative providers.\textsuperscript{88}

The quality of nonphysician health care professionals has been demonstrated, and the potential use for alternatives to physicians goes beyond providing limited routine services. Between seventy-five and eighty percent of adult primary care and ninety percent of pediatric primary care services could safely be delegated to alternative health professionals.\textsuperscript{89} International comparative data suggests that at least three-quarters of routine obstetrical care can be handled by nurse midwives.\textsuperscript{90} Just focusing on nurse practitioners alone, society could save between $6.4 billion and $8.75 billion annually if their services were used more efficiently.\textsuperscript{91}

III. LIMITATIONS ON THE USE OF ALTERNATIVE PROVIDERS' SERVICES

Despite their appeal and quality, there are practical and legal barriers to the widespread appropriate use of alternative providers. These include unauthorized practice of medicine

\textsuperscript{87} See Aiken & Sage, supra note 25, at 196 ("Advanced practice nurses are frequently the only providers for poor or remote populations, often because many physicians find this work undesirable."). As Donna Diers notes, for example, "[I]t has been well documented that the patients first turned over to nurses in expanded roles are the most sick, the poorest, the most complicated, the most socially undesirable, [and] the most socially at risk . . . ." Diers, supra note 7, at 277.

\textsuperscript{88} Barbara Safriet notes the absurdity of restricting alternative providers' independent practice only to underserved areas, asking "if APNs [advanced practice nurses], practicing autonomously, can effectively care for rural and poor inner-city patients, relatively high-health-risk populations whose economic or social status often results in poor nutrition, low birth-weight babies and the like, why cannot these same providers practice in suburban or urban areas without MD supervision?" Safriet, supra note 37, at 454.

\textsuperscript{89} LeRoy, supra note 86, at 300; Jones & Cawley, supra note 6, at 1270 (finding that "[i]n ambulatory managed care settings, [physician assistants] have been shown to be capable of handling approximately 80% of the health care services required to manage patient problems at physician-equivalent levels of patient satisfaction and quality of care"). American Nurses Association President Virginia Trotter Betts argues that "[s]tudies show that 50% to 80% of primary-care services traditionally offered by physicians can be handled by licensed nonphysician providers with the same or better results." Virginia T. Betts, Letters to Fortune: Nurses and the Doctor Shortage, FORTUNE, Jan. 11, 1993, at 102, 102.

\textsuperscript{90} Aiken & Sage, supra note 25, at 195.

laws, limitations on direct reimbursement to alternative providers, laws that limit alternative providers' power to prescribe, practices excluding them from admitting privileges at health care institutions, and the inability to obtain malpractice insurance.

In many instances, the barriers to the use of alternative providers have been erected due to pressures from their main competitors, physicians. Physicians convince legislatures to restrict the scopes of practice of other providers and pressure prosecutors to bring criminal actions against nonphysician providers. Physician groups have tried to eliminate the practice of various alternative health care providers including acupuncturists, chiropractors, homeopaths, midwives, naprapaths, and naturopaths. In addition, since physicians are the main breadwinners for hospitals, health maintenance organizations, and other health care institutions,


93. See Korte, supra note 84, at 55 (stating that it is doctors who usually bring complaints against nurse midwives).


95. See Wilk v. American Medical Ass'n, 719 F.2d 207, 211 (7th Cir. 1983) (addressing chiropractors' allegation that the American Medical Association engaged in a conspiracy to eliminate chiropractors), cert. denied, 467 U.S. 1210 (1984).

96. See In re Guess, 393 S.E.2d 832, 834-35, 838 (N.C. 1989) (concluding that the North Carolina Board of Medical Examiners can revoke the license of a physician practicing homeopathic medicine even if the practice does not pose a threat to patients or the public), cert. denied, 498 U.S. 1047 (1991).

97. See Bowland v. Municipal Court, 556 F.2d 1081, 1084, 1086-87 (Cal. 1976) (deciding that the California statute prohibiting the unlicensed practice of healing arts is not unconstitutionally broad or vague and applies to midwives).

98. See Maguire v. Thompson, 957 F.2d 374, 375 (7th Cir.) (dismissing plaintiff's claim that the Illinois Medical Practice Act lacked a rational basis to exclude doctors of naprapath from the licensing provisions of the Act), cert. denied, 113 S. Ct. 73 (1992).

99. See Idaho Ass'n of Naturopathic Physicians v. FDA, 582 F.2d 849, 851 (4th Cir. 1978) (challenging state regulations giving medical doctors the power to establish requirements for naturopaths as a due process violation), cert. denied, 440 U.S. 976 (1979).

100. See Susan A. Cejka, Physician Recruiting: Do You Know Where Your Dollars Go?, HEALTHCARE FIN. MGMT., Nov. 1991, at 52, 60 (noting that the most important factor in a hospital's success may be physician staffing because "[w]ithout physicians, hospitals would have no patients or revenue"); Donald A. Sands & Bruce A. Rendina, Medical Offices Buildings—The Challenges and the Rewards, 20 HEALTHCARE FIN. MGMT. 1, 1 (1992) (noting that better physician relations can increase hospital revenues); see also John E. Hill & Jan Pessolano, Physician Relations: Executive Role Vital During Succession and Transition Planning, HEALTHCARE FIN. MGMT., Sept. 1994, at 20, 22 ("[R]etiring physicians are likely to be among the heaviest admittees of patients, and therefore the largest contributors to the hospital's
they exert a large amount of power over the fashioning of policies to govern these institutions. Physician groups have bullied hospitals into adopting policies that favor physicians and disadvantage or even eliminate alternative health care providers, even when there is no evidence that such policies are necessary to protect patients.\textsuperscript{101} Michael Jacobs points out that "[i]t is well known in health law circles that physicians and hospitals share an institutional history of hostility to other kinds of health care practitioners."\textsuperscript{102}

In some institutions, physician-controlled medical staffs have refused to allow alternative providers such as nurse anesthetists\textsuperscript{103} or midwives\textsuperscript{104} to practice in the hospital setting.\textsuperscript{105} Because hospitals' main "customers" are doctors, the opposition of doctors to nonphysicians has been a factor in privilege denial. In Washington, D.C., for example, doctors voted to exclude nurse midwives from the Washington Hospital Center despite a successful pilot project there.\textsuperscript{106} Hospitals may also be reluctant to grant privileges to midwives and other nonphysician practitioners out of fear that their physicians will go on strike, as some physicians have done when osteopaths were given hospital privileges.\textsuperscript{107} When alternative

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\item 101. See Polly Shackleton, \textit{Doctors Aren't the Only Pros} . . . , \textit{WASH. POST}, June 5, 1963, at C8 (suggesting that many alternative health care providers are prohibited from practicing at Washington D.C. hospitals because physicians are empowered to deny privileges).


\item 103. See Bhan v. NME Hosps., Inc., 929 F.2d 1404, 1408 (9th Cir.) (discussing a hospital policy that prohibited nurses from applying for anesthesia privileges), \textit{cert. denied}, 502 U.S. 994 (1991). In many cases, physicians have denied staff privileges to alternative providers such as osteopaths. See, e.g., Fiegel v. Christian Hosp. Northeast-Northwest, 4 F.3d 682, 684 (8th Cir. 1993) (dismissing an antitrust suit by two osteopaths against a hospital and staff employees for denying them staff privileges).

\item 104. See Nurse Midwifery Assoc. v. Hibbett, 918 F.2d 605, 607-08 (6th Cir. 1990) (involving a suit alleging that the defendant physicians entered into a conspiracy to keep nurse midwives from practicing in hospitals by denying them hospital privileges), \textit{cert. denied}, 502 U.S. 952 (1991).

\item 105. One commentator has found that in the antitrust context "in)physician providers' most common allegations have centered on staff privileges." Brian McCormick, \textit{Beware Antitrust Pitfalls in Dealing with Other Providers}, AM. MED. NEWS, Apr. 19, 1993, at 7, 7; see also MICHAEL R. POLLARD & ROBERT F. LEIBENLUFT, FTC POLICY PLANNING ISSUES PAPER: ANTI TRUST AND THE HEALTH PROFESSIONS 101-02 (1981) (commenting that certified nurse midwives, pediatricians, clinical psychologists, osteopaths, and other nonphysician providers are denied hospital privileges, thereby restricting patients' access to alternative care).

\item 106. See Shackleton, \textit{supra} note 101, at C8.

providers are allowed to practice in hospitals and other health care institutions, they are often subject to absurd rules that are purportedly directed at ensuring quality of alternative health care practitioners, but may actually be designed solely to enhance physician income. For example, many hospitals require a physician’s presence at each nurse midwife-assisted birth, whether the patient’s condition merits it or not.108 In one community, a hospital provides that midwife-attended births must be supervised by physicians between the hours of 7:00 a.m. and 7:00 p.m., but not after 7:00 p.m., even though the nurse midwives and their practices are the same throughout the day.109

Hospitals themselves may have conflicts of interest that prevent them from making appropriate use of alternative providers. In teaching institutions, physicians and administrators may choose not to refer patients to the available nurse midwives because of the need for “‘teaching material’” for medical students and residents.110 Hospital administrators may also be concerned that because these alternative groups engage in less intrusive care than do physicians,111 they will generate less income for the hospital than do physicians.112

Physicians’ opposition to alternative providers is manifested in other policies as well.113 Women are sometimes denied prenatal care at major hospitals because they are honest about their intention to have a home birth attended by a midwife.114 Physician-dominated malpractice insurance companies

have been known to strike in hospitals which have given privileges to osteopaths over medical staff objections.7)

108. Diers, supra note 7, at 286.
109. Id. at 286-87.
110. See id. at 281 (discussing the competition for “‘teaching material’” when physicians and nurse midwives practice side by side).
111. Refer to notes 78-80 supra and accompanying text (suggesting that physicians order unnecessary services).
112. See Diers, supra note 7, at 284 (commenting that because nurse midwives have a noninterventionist practice that orders fewer high-technology tests and results in shorter hospital stays, nurse midwifery practice may save the patient money but generate less money for the hospital). Dean Safriet points out that “[w]hile society would clearly benefit from the reduction of illness and the costs of illness-related care, the effects of such success upon hospital or private practice revenues may not be viewed as a benefit by their owners.” Safriet, supra note 37, at 438.
113. This is in keeping with organized medicine’s traditional opposition to measures that were seen as threatening to doctors’ economic position or professional domain, such as when doctors have boycotted prepaid group practice. See STARR, supra note 86, at 25 (discussing attempts by doctors to eliminate competition, such as the prepaid group practice plan).
114. See Mark Marcoplos, Birth Regrets, CHAPEL HILL HERALD, Aug. 5, 1994, at 4 (relating the story of a woman who was denied prenatal care at a major hospital after hospital administrators heard of her intention to have a home birth).
have instituted surcharges or terminated coverage of physicians who have agreed to serve as back-up doctors for alternative providers (such as obstetricians who cooperate with midwives).\textsuperscript{115} Beyond the issue of malpractice insurance for back-up physicians, alternative providers find it difficult to obtain malpractice insurance for their own practices despite the fact that they are sued much less frequently than physicians.\textsuperscript{116} As one insurance journal points out, "few companies underwrite policies for alternative practitioners."\textsuperscript{117} A study by the Institute of Medicine of the National Academy of Sciences found that only one commercial carrier has been willing to cover nurse midwives—and only for an amount below that required by most hospitals as a condition of staff privileges.\textsuperscript{118} This may cause an increasing problem if states follow the Florida Legislature by adopting statutes that require allied health professionals to carry malpractice insurance.\textsuperscript{119}

The American Medical Association (AMA) has undertaken numerous efforts to quash alternative practitioners. The AMA House of Delegates adopted a resolution "oppos[ing] any attempt at empowering nonphysicians to become unsupervised primary medical care providers and be directly reimbursed for case management activities."\textsuperscript{120} Local medical organizations have taken similar positions, opposing legislation that would

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\textsuperscript{115} See Sarah D. Cohn, Professional Liability Insurance and Nurse-Midwifery Practice, in 2 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 104, 109-10 (Victoria P. Rostov & Roger J. Bulger eds., 1989) (discussing policies of some liability insurers of imposing premium surcharges on physicians who work with nurse midwives); Milt Freundenheim, Doctors Battle Nurses Over Domains in Care, N.Y. TIMES, June 4, 1983, at 1, 8 (relating the story of a suit by two midwives against a group of doctors when their backup physician's malpractice insurance was cancelled).

\textsuperscript{116} See Cohn, supra note 115, at 108 (citing 1982 survey data indicating that only 55 nurse midwives (or 5.2%) had ever been sued, compared to 70% of obstetricians). For a more detailed discussion of this issue, refer to notes 56-58 supra and accompanying text.

\textsuperscript{117} O'Connell, supra note 8, at 75.

\textsuperscript{118} See Cohn, supra note 115, at 107, 109 (noting that the only available malpractice insurance policy for nurse midwives caps coverage at a point below the minimum hospitals generally require).

\textsuperscript{119} See FLA. STAT. ANN. § 455.2456 (West Supp. 1995) (mandating that various nonphysician providers must maintain medical malpractice insurance or provide proof of financial responsibility as a prerequisite for licensure); see also Cohn, supra note 115, at 108-09 (relating the story of a group of Connecticut nurse midwives who were forced to close their practices when they were unable to find malpractice insurance).

\textsuperscript{120} Safriet, supra note 37, at 455 n.126 (quoting the proceedings of the AMA's House of Delegates). Safriet notes that "[c]onsistently, individual physicians and medical associations have lobbied against any legislative efforts to acknowledge prescriptive authority as part of the APN's [advanced practice nurse's] scope of practice." Id. at 461.
extend the definition of medical practice to cover nonphysician providers.\textsuperscript{121}

The battle lines have also been drawn in the courtroom. Unauthorized practice of medicine suits which can bring penalties of up to a $5,000 fine and 6 years imprisonment\textsuperscript{122} have been brought at the instigation of physicians against nonphysician practitioners such as chiropractors who give physical exams\textsuperscript{123} or nurse practitioners who provide routine breast and pelvic examinations.\textsuperscript{124}

There is very little legal recourse for alternative providers against these self-serving actions of physicians. Various alternative practitioners have filed antitrust suits against physicians\textsuperscript{125} and the AMA.\textsuperscript{126} The most visible antitrust case brought by nonphysician providers was Wilk v. American Medical Ass'n,\textsuperscript{127} in which the district court found that the AMA intended to "destroy a competitor," namely, chiropractors.\textsuperscript{128}

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\textsuperscript{121} For example, the Oregon Medical Association opposed independent prescribing privileges for nurse practitioners. See Leigh Page, Some Nurses Moving Toward Independence, Wider Practice, AM. MED. NEWS, Mar. 21, 1994, at 3, 36 (discussing how nurse practitioners received independent prescribing privileges despite the Oregon Medical Association's opposition).

\textsuperscript{122} See NEV. REV. STAT. ANN. § 630.400 (Michie 1995).

\textsuperscript{123} The Michigan Court of Appeals ruled that chiropractors violated the medical licensing law when they performed physical exams and ultrasound or prescribed vitamins and food supplements. See Attorney Gen. v. Beno, 335 N.W.2d 31, 34-36 (Mich. Ct. App. 1983). The Supreme Court of Michigan affirmed that chiropractors may not perform physical exams or ultrasounds. See Attorney General v. Beno, 373 N.W.2d 544, 559, 562-63 (Mich. 1985). However, the court decided that recommending or dispensing of a vitamin or food supplement is permitted in some circumstances. See id. at 566.

\textsuperscript{124} See Freundenheim, supra note 115, at 8 (reporting that Missouri recommended criminal prosecution of two nurse practitioners for "giving breast and pelvic exams and taking Pep smears, inserting IUD's [sic], and ordering contraceptive pills").

\textsuperscript{125} See, e.g., id. (reporting two midwives as suing a group of doctors for anti-trust violations under the Sherman Act).

\textsuperscript{126} Chiropractors have won the latest round of their antitrust suit charging that the AMA tried to run them out of business. On September 19, 1983, the Seventh Circuit Court of Appeals overturned a jury verdict in favor of the AMA, saying that it was significant that the jury understand that a generalized public interest motive affords no legal excuse for such economic warfare." Wilk v. American Medical Ass'n, 719 F.2d 207, 228 (7th Cir. 1983), cert. denied, 467 U.S. 1210 (1984); see also Douglas Frantz, Antitrust Decision for AMA Overturned, CHI. TRIB., Sept. 20, 1983, § 2, at 5 (discussing the Wilk verdict). Also, on February 7, 1990 the Seventh Circuit held that the AMA had illegally boycotted chiropractors. See Wilk v. American Medical Ass'n, 895 F.2d 352, 355 (7th Cir.). cert. denied, 496 U.S. 927, and cert. denied, 498 U.S. 982 (1990).

\textsuperscript{127} 895 F.2d 352 (7th Cir.), cert. denied, 496 U.S. 927, and cert. denied, 498 U.S. 982 (1990).

\textsuperscript{128} Id. at 361 (quoting Wilk v. American Medical Ass'n, 671 F. Supp. 1465, 1478 (N.D. Ill. 1987), aff'd, 895 F.2d 352 (7th Cir.), cert. denied, 496 U.S. 927, and cert. denied, 498 U.S. 982 (1990)).
The appellate court likewise noted that the AMA had tried “to eliminate chiropractic” by actions designed “to prevent medical physicians from teaching at chiropractic colleges or engaging in any joint research, and to prevent any cooperation between the two groups in the delivery of health care services.” The AMA failed to show that its actions were reasonably based on concerns for the quality of chiropractors’ care and that there were no less restrictive means of accomplishing its goal.

The AMA’s House of Delegates had labeled chiropractic an “unscientific cult” and made it unethical for physicians to have a professional association with “unscientific practitioners.” In 1980, after the antitrust suit by chiropractors, the AMA changed its ethical principle, but the AMA did not inform its members that associating with chiropractors was now acceptable. The Court of Appeals for the Seventh Circuit found the AMA to have engaged in an illegal boycott under the Sherman Act and affirmed the district court’s injunction, which required the AMA to publish the district court’s order in the Journal of the American Medical Association, mail a copy of the order to each member, and revise current statements to refer specifically to chiropractors.

Despite this visible victory of alternative providers against the AMA, the more common variety of antitrust suits against physicians and hospitals are often difficult for alternative providers to win. Hospitals that deny admitting privileges to nurse anesthetists, midwives, or other allied health professionals can often fend off an antitrust action based on § 1 of the Sherman Act by claiming that they do not have sufficient market power to restrain trade or that the exclusion is pro-competitive because it allows them to attract consumers with a claim of high quality service due to its all-physician staff.

129. Id. at 356.
130. Id.
131. See id. at 363.
132. Id. at 356.
133. See id. at 366.
135. Wilk, 865 F.2d at 366, 378.
136. Section 1 of the Sherman Act provides that “[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce . . . is declared to be illegal.” 15 U.S.C. § 1.
137. See BCB Anesthesia Care, Ltd. v. Passavant Memorial Area Hosp. Ass’n, 36 F.3d 664, 666 (7th Cir. 1994).
138. See Bhan v. NME Hosp’s, Inc., 929 F.2d 1404, 1412 (9th Cir.) (commenting that restrictions on staff privileges help hospitals “provide more efficient, higher
Some courts reason that the health services market is national, and so long as an alternative provider might be granted privileges at a hospital elsewhere in the country, there is no antitrust violation.\textsuperscript{139} Alternative providers or their back-up physicians who are harmed by the action of a medical staff or physician-run insurance plan may have difficulty showing that the physicians were illegally conspiring rather than just pursuing individual interests.\textsuperscript{140} Another problem is that antitrust doctrine shields physician groups from liability for efforts to restrain trade by petitioning legislators,\textsuperscript{141} government agency officials,\textsuperscript{142} and courts.\textsuperscript{143}

Denial of privileges is typically challenged as constituting a boycott violative of § 1 and § 2 of the Sherman Act.\textsuperscript{144} Two recent cases illustrate the difficulty nonphysicians confront in making their claims. In \textit{Bhan v. NME Hospitals},\textsuperscript{145} Manteca Hospital instituted a policy which excluded nonphysician

\textsuperscript{139} See, e.g., \textit{BCB Anesthesia Care}, 36 F.3d at 668 (noting that the relevant health care market may include a hospital 25 miles away from the defendant hospital and therefore, there is not an antitrust violation).

\textsuperscript{140} See, e.g., \textit{Nurse Midwifery Assocs. v. Hibbett}, 918 F.2d 605, 616-17 (6th Cir. 1990) (stating that when competing physicians join together to sell malpractice insurance, they operate as a single entity rather than independent conspiring actors), \textit{cert. denied}, 502 U.S. 952 (1991).

\textsuperscript{141} See \textit{Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.}, 365 U.S. 127, 135 (1961) (upholding the "basic construction" of the Sherman Act "that no violation of the Act can be predicated upon mere attempts to influence the passage or enforcement of laws").

\textsuperscript{142} See \textit{United Mine Workers v. Pennington}, 381 U.S. 657, 669-70 (1965) (declining to limit \textit{Noerr} to lobbying for statutes and stating that "\textit{Noerr} shields from the Sherman Act a concerted effort to influence public officials regardless of intent or purpose").

\textsuperscript{143} \textit{California Motor Transp. Co. v. Trucking Unlimited}, 404 U.S. 508, 510-11 (1972) (concluding that "it would be destructive of rights of association and of petition" to find a violation of the Sherman Act when groups "use the channels and procedures of state and federal agencies and courts to advocate their causes and points of view respecting resolution of their business and economic interests \textit{vis-a-vis} their competitors"). For an explanation of the application of these doctrines in the health care context, see \textit{Wilk v. American Medical Ass'n}, 895 F.2d 352, 357-58 (7th Cir.), \textit{cert. denied}, 496 U.S. 927, \textit{and cert. denied}, 498 U.S. 982 (1990).

\textsuperscript{144} See, e.g., \textit{Flegel v. Christian Hosp., Northeast-Northwest}, 4 F.3d 682, 685 (8th Cir. 1993) (alleging two violations of § 1 and one violation of § 2 of the Sherman Act because a hospital and staff doctors denied hospital privileges to two osteopaths); \textit{Bhan v. NME Hosps., Inc.}, 929 F.2d 1404, 1407 (9th Cir.) (invoking a class of nonphysician anesthesia providers' allegations of a hospital's violation of § 1 and § 2 of the Sherman Act), \textit{cert. denied}, 502 U.S. 994 (1991). While § 1 of the Sherman Act prohibits restraints of trade, § 2 provides that "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize . . . trade or commerce . . . shall be deemed guilty of a felony." 15 U.S.C. § 2.

anesthetists. A certified registered nurse anesthetist asserted that the hospital’s policy constituted a boycott in violation of the Sherman Act. The Ninth Circuit Court of Appeals reasoned that “the choice of physician over nonphysician providers may actually sharpen competition by making Manteca a more attractive competitor in the patient market.” The court found that the nurse anesthetist failed to prove that Manteca’s policy restrained competition in a relevant market, and therefore his claim failed under the rule of reason as well. Similarly, the Eighth Circuit Court of Appeals in Flegel v. Christian Hospital, Northeast-Northwest found that denying staff privileges to two doctors of osteopathy was not a per se Sherman Act violation. Additionally, the court held the market power of the hospital was not great enough to support a claim for an unreasonable restraint of trade or a monopoly.

As competition increases, so too do the barriers for nonphysicians. One commentator has suggested that physicians are likely to have the advantage in managed competition “[i]f a small number of competing networks each want to be the “quality provider,” they are all likely to see either exclusive or predominant use of physicians as a valuable marketing tool.” Bhan and Flegel indicate that this approach will be protected by the courts.

Another anticompetitive tactic employed to discourage practice by health professionals requiring some type of physician alliance—such as nurse midwives or nurse practitioners—is denial or cancellation of malpractice insurance for physicians who work in association with such practitioners. This practice was challenged under § 1 of the Sherman Act by two nurse midwives and the obstetrician with whom they affiliated in Nurse Midwifery Associates v. Hibbett. In that case, physician members of the State Volunteer Mutual

146. See id. at 1407-08.
147. Id. at 1407.
148. Id. at 1412.
149. See id. at 1414.
150. Id. Because Bhan provided no legal analysis of his § 2 claim, the court treated his claim as abandoned. See id.
151. 4 F.3d 662 (8th Cir. 1993).
152. See id. at 691.
153. See id.
155. For more discussion on this issue, refer to note 115 supra and accompanying text.
Insurance Company (SVMIC) had cancelled a physician's malpractice insurance because he had a contract with a group of nurse midwives. The Sixth Circuit Court of Appeals held that "[s]ince SVMIC and its members were theoretically capable of conspiring, the question remains upon remand whether physicians who had previously pursued their own interests separately, in this instance combined to unlawfully restrain competition among providers of maternity care." In finding this a question of fact, the court reasoned that rather than composing a group of former competitors involved in a joint venture in competition with other malpractice insurers (not an illegal conspiracy), SVMIC’s action could be seen as "conduct of physicians who retain their identity as individuals who compete among themselves and with plaintiffs in providing maternity care services and combine to unreasonably restrain competition in that field by denying malpractice insurance coverage to a competing maternity care provider."

_Nurse Midwifery Associates_ suggests that the anticompetitive barriers to allied health professionals' practice may also be indirect: by making it difficult if not impossible for allied health professionals to associate professionally with physicians, the practices of nonphysicians may be severely limited if not rendered impossible. Further, if each of the physicians were just individuals protecting his or her own interest, no antitrust violation would be found.

Another arena in which the turf war between physicians and nonphysician health care providers is played out is reimbursement. By denying allied health professionals membership or similar rates as physicians, health care plans can effectively eliminate the competition that nonphysicians may generate for similar services. Under some circumstances, these exclusionary practices may amount to violation of § 1 of the Sherman Act.

For example, in _Hahn v. Oregon Physicians' Service_, several podiatrists contended that Oregon Physicians' Service (OPS), a physician-controlled health plan, violated the Sherman Act by excluding podiatrists from membership and by reimbursing nonmembers at a lower rate than member physicians. The U.S. District Court for the District of Oregon

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157. _Id._ at 615.
158. _Id._ at 616.
159. _Id._
160. _See id._ at 611-12 (identifying one necessary element of an antitrust violation as "concerted" rather than "unilateral" behavior).
162. _See id._ at *1.
found that the action by OPS did in fact violate § 1 of the Sherman Act. Since “OPS was a physician controlled organization in which the board members acted as agents to the member physicians,” and plaintiffs could show that the group held a “rational economic motive to conspire,” plaintiffs were able to prove that defendants had conspired. The court found that “the overlap between the practices of podiatrists and physicians [was] sufficient to support a finding that physicians share substantially similar economic interests with podiatrists.” The court reasoned that although the actual dollars and cents impact was slight with regard to individual physicians, “when taken as a whole, and combined with the synergistic effect resulting from the exclusion of other allied medical providers . . . the financial benefit to OPS member physicians was significant.” The court recognized that the exclusion of podiatrists from the health plan and the two-tiered reimbursement schedule constituted a boycott and an unreasonable restraint of trade. By excluding allied health professionals from health plans and reimbursing them (as nonmembers) at lower levels than physicians, subscribers are likely to seek services from physician members regardless of the quality of the service or the provider.

In some instances, successful antitrust actions have been brought against insurers that have refused to reimburse alternative providers who practice independently. *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia* considered the refusal by Blue Shield, a physician-controlled plan, to pay psychotherapist fees unless the services were billed through a physician. Blue Shield argued that the rule was necessary to prevent needless psychotherapy when the health problems had a physical basis. The court, however, rejected the restriction because it did not in fact fulfill that goal since the Blue Shield policy allowed the service to be billed through any physician “not just those who regularly treat mental and

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163. See id. at *14.
164. Id. at *6-7.
165. Id. at *10-11.
166. Id. at *11.
167. See id. at *11, 14.
168. See, e.g., id. at *11 (noting that because the insurance plan did not reimburse for most podiatric services, subscribers often cancelled their appointments or discontinued their treatment).
170. See id. at 478.
171. See id. at 495.
nervous disorders." The Supreme Court in *Blue Shield of Virginia v. McCready*, considering a related case, said that consumers have a right to bring suit against the insurer when they are forced by the insurance plan to consult a physician before getting access to a psychotherapist.

IV. THE REGULATION OF ALTERNATIVE MEDICINE

Increased attention has been focused on expanding the role of alternative providers in the context of health care reform, leading to numerous law review articles and greater social debate on the subject. Because private law in the form of antitrust suits does not guarantee that alternative providers will be allowed to offer their services to consumers in appropriate circumstances, attention needs to be focused on changing state laws to assure that alternative providers are able to practice to the full extent of their capabilities.

The main barrier to expanded practice by alternative providers are the medical licensing laws, which define broadly the term "practice of medicine" and then make it a crime for anyone other than a licensed physician to undertake those activities. Medical groups lobbied these medical licensing laws through state legislatures a century ago. According to Walter Gellhorn, professionals lobby for licensure for their group

172. *Id.*
174. *See id.* at 467, 475, 485 (holding that an employee who was denied insurance coverage for a visit to the psychologist because she had not submitted the bill through a physician had standing to bring a claim under § 4 of the Clayton Act).
175. *See, e.g.*, Aiken & Sage, *supra* note 25, at 193-94 (calling for increased use of advanced practice nurses to make health care more cost-effective and accessible); Antoinette D. Inglis & Diane K. Kjervik, *Empowerment of Advanced Practice Nurses: Regulation Reform Needed to Increase Access to Care*, 21 J. L. MED. & ETHICS 193, 194 (1993) (exploring the issue of regulatory constraints on advanced practice nursing and offering recommendations for improving access to cost-effective, high-quality primary health care); Safriet, *supra* note 37, at 421 (arguing for lifting restrictions that prevent advanced practice nurses from providing less expensive, high quality care).
176. Refer to notes 125-54 *supra* and accompanying text.
177. *See, e.g.*, ALA. CODE §§ 34-24-50 to -51 (1991) (defining the practice of medicine as "[t]o diagnose, treat, correct, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality" and providing a penalty of up to $1000 and 6 months imprisonment for unlicensed practice).
178. *See Tom Christoffel*, *Hiring on the Cheap: Health Care Costs, the Eclipse of Physicians and Change in Licensing Laws*, 4 ST. LOUIS U. PUB. L.F. 57, 59 (1984) (noting that "[b]y the end of World War I, the American Medical Association had been transformed from an academic and scientific organization into a powerful guild representing the small businessman, medical practitioner").
“always on the purported ground that licensure protects the uninformed public against incompetence or dishonesty, but invariably with the consequence that members of the licensed group become protected against competition.”

The licensing laws work in the following way. Each state defines the practice of medicine and limits the practice to licensed physicians. In some states, the definition is all-encompassing, requiring a medical license for advising anyone about “any . . . condition, physical or mental, real or imaginary.” At least twenty jurisdictions include the term “condition”—a wide umbrella category that could conceivably cover any human state, healthy or not, from drowsy to hungry, sad to excited, pregnant to comatose. In California, the courts have interpreted the practice of medicine definition to apply to aiding patients in dealing with obesity and nervousness, requiring those who treat those conditions to have a medical license. California courts have also held that while pregnancy is not a disease, it is nonetheless a “‘physical condition,’” so that when a lay midwife cares for a pregnant woman she is engaged in the unauthorized practice of medicine.
In a number of states, the practice of medicine definition, and thus the licensing requirement, encompasses not only hands-on activities but also advising a person about the condition, cause, or diagnosis of an ailment, or suggesting or recommending a course of action a person should follow with respect to his or her condition. Those provisions could be used to stop newspapers or other publishers from writing about health care matters; in fact, a medical self-help book has been enjoined under the laws prohibiting the unauthorized practice of medicine. A pharmacist recommending vitamins after being told a person’s symptoms has also been held to be the unauthorized practice of medicine. In addition to the First Amendment reasons for promoting broad consumer access to health care information, such an approach could result in enormous cost savings as well. The Health Strategy Group analyzed physicians visits in one year and found that patients spend almost $800 million for physician visits simply to obtain information.

Even the medical practice acts that focus on treatment, a service more traditionally related to doctoring, have an excessive reach. The vast reach of the medical practice acts is illustrated by Hawaii’s definition of the practice of medicine as including “the use of drugs and medicines, water, electricity, hypnotism, or any means or method, or any agent, either tangible or intangible, for the treatment of disease in the human


188. See Kelley v. Texas State Bd. of Med. Examiners, 467 S.W.2d 539, 544-45 (Tex. Civ. App. 1971, writ ref'd n.r.e.) (holding “that the publication [of the book], ‘One Answers to Cancer,’ is a diagnosis, treatment, and offer of treatment and therefore constitutes the practice of medicine”), cert. denied, 405 U.S. 1073 (1972).


190. See Andrews, supra note 92, at 23.
subject.\textsuperscript{191} At its broadest, the definition of the practice of medicine includes all endeavors related to human illness or health.\textsuperscript{192} It generally does not matter whether the alleged practitioner requests or accepts a fee or not, as various cases have held that the receipt of pay is irrelevant.\textsuperscript{193}

Because nearly all activities regarding health or disease fall within the scope of the medical licensing laws,\textsuperscript{194} an individual providing any health care information or service may be required to have a medical license. Moreover, many alternative professionals cannot offer the range of services of which they are capable because of restrictions in state licensing laws.\textsuperscript{195} Chiropractors,\textsuperscript{196} midwives,\textsuperscript{197} a lay staff member of the Los


\textsuperscript{192} \textit{See} Christoffel, \textit{supra} note 178, at 69 (noting that “if in most states, medical practice is ‘universally defined in broad terms which encompass all health service functions’” (footnote omitted)).

\textsuperscript{193} \textit{See}, e.g., People v. Albreston, 235 P. 87, 90 (Cal. Dist. Ct. App. 1925) (holding that the Medical Act applies whether or not the service is gratuitous); People v. Vermillion, 158 P. 504, 504 (Cal. Dist. Ct. App. 1916) (rejecting defendant’s theory that he could not be convicted of unlicensed practice of medicine unless he accepted fees). Under at least 34 of the state medical practice acts, a person may be found guilty of unauthorized practice of medicine if he or she gratuitously performs any activity within the definition of the practice of medicine. \textsc{Andrews, supra} note 92, at 24.

The licensing requirements apply equally to those who, on an on-going basis, do any of the activities listed as within the definition of the practice of medicine and those who occasionally (or even on a single occasion) treat or advise. Cases have held that practice does not imply a “repeated” effort; a single instance will suffice. \textit{See}, e.g., People v. Sher, 561 N.Y.S.2d 872, 875-76 (Sup. Ct. 1990) (concluding “that the unauthorized practice of medicine is not a continuing offense”). In California, the practice in connection with each patient qualifies as a separate violation. \textit{See} People v. Eckley, 108 Cal. Rptr. 52, 57 (Ct. App. 1973) (“In practicing medicine without a license with numerous and separate patients, the practice in connection with each patient would be a separate violation divisible in time from the others.”).

This perspective is also reflected in the penalty sections of the statutes, which in some states make each instance or each day a separate offense. \textit{See}, e.g., \textsc{Okla. Stat. Ann.} tit. 59, \S 491 (West Supp. 1995) (“Each day’s practice shall constitute a separate and distinct offense.”); \textsc{Tenn. Code Ann.} \S 63-6-203(a)(2) (Supp. 1994) (“Each time any person practices medicine or surgery without first obtaining a valid certificate or renewing a certificate constitutes a separate offense.”). Clearly, the broad sweep of the medical practice acts is not limited to those who offer or perform health services as a vocation.

\textsuperscript{194} \textit{Refer} to notes 180-84 \textit{supra} and accompanying text.

\textsuperscript{195} The legality of practice without a license is of concern not only to individuals who practice, but to health care institutions as well.


\textsuperscript{197} \textit{See} Ellen L. Hodgson, Comment, \textit{Restrictions on Unorthodox Health Treatment in California: A Legal and Economic Analysis}, 24 \textsc{UCLA L. Rev.} 647, 651 n.23 (1977) (citing an unpublished 1973 California case where a midwife was found to be practicing medicine by taking the blood pressure of a pregnant woman).
Angeles Feminist Women's Health Center,198 health food store owners recommending certain foods and food supplements,199 abortion counselors,200 and acupuncturists201 have been prosecuted for the unauthorized practice of medicine, and publication and distribution of a book has been enjoined as violating the medical practice acts.202 One state medical disciplinary board committee has opined that marketing diagnostic software to the general public may violate the medical licensing laws.203

Unauthorized practice actions have been brought against over 145 midwives in 36 states.204 The complaints are very rarely brought by patients, but by the midwives' competitors—doctors, medical professional organizations, or other medical entities.205 Actions are brought even when the midwives have not caused harm to any patient. For example, in 1994, the New York Health Department issued injunctions against two midwives who had successfully attended 2500 home births with no infant or maternal mortality.206 While the midwives often win their cases, their practices, finances, and personal lives are damaged considerably in the process. For example, despite the fact that the Missouri Nursing Board authorized a birthing center, an unauthorized practice of medicine action was brought against a midwife at the center.207 Law enforcement officials raided the midwife's office, removing computer

198. See Andrews & Levin, supra note 34, at 44 (reporting the use of a medical practice act against "a feminist who gave a woman a yogurt treatment for a vaginal infection").

199. See Pinkus v. MacMahon, 29 A.2d 885, 886 (N.J. 1943) (finding that a man who sold food and food supplements as a remedy for physical ailments that he diagnosed violated the medical practice statute).


202. See Kelley v. Texas State Bd. of Med. Examiners, 467 S.W.2d 539 (Tex. Civ. App. 1971, writ ref'd n.r.e.), cert. denied, 405 U.S. 1073 (1972). The court held, inter alia, that the publication of a cancer book was a "diagnosis, treatment, and offer of treatment and therefore constitutes the practice of medicine." Id. at 544-45.

203. Andrews, supra note 92, at 6 (citing a report by the Board of Medical Quality Assurance).

204. Korte, supra note 84, at 54.

205. See id. at 55.

206. See id. at 52.

207. Id. at 54, 55.
disks and destroying files.\textsuperscript{208} Although charges were later dropped, she expended $40,000 in legal fees.\textsuperscript{209} In 1994, the thirteen year old daughter of a California midwife was held at gunpoint by police searching for evidence.\textsuperscript{210}

The licensing laws not only restrict alternative practitioners in their independent practice; they also limit the uses that health care institutions may make of their nonphysician staff. Hospitals, clinics, nursing homes, and other institutions may be unsure if they are breaking the law by using health care providers other than physicians.\textsuperscript{211} Many routine patient care functions commonly performed by nonphysician staff members in these institutions violate the medical licensing laws of the states in which they are located.\textsuperscript{212} Health care institutions may be reluctant to use nonphysician employees to their maximum for fear that the technical violation of the licensing law might be used by a patient as prima facie evidence of malpractice.\textsuperscript{213} As an example, nurse practitioners are capable of assisting in the care of institutionalized elderly patients, but only about 250 of the more than 23,600 nursing homes in the United States have nurse practitioners on their staff.\textsuperscript{214} When institutions such as health maintenance organizations bring suits against a medical licensing board to determine if alternative providers such as nurses may legally engage in certain practices, they may be held not to have standing to sue,\textsuperscript{215} so

\begin{itemize}
\item \textsuperscript{208} Id. at 55.
\item \textsuperscript{209} Id.
\item \textsuperscript{210} Id. at 56.
\item \textsuperscript{211} See ANDREWS, supra note 92, at 7 (citing a report by the Board of Medical Quality Assurance).
\item \textsuperscript{212} Id. Because the current medical licensing laws do not allow hospitals to assign tasks to nonphysician staff members according to their competence, Nathan Hershey has advocated that individual licensure be replaced by institutional licensure in which the health care institutions themselves "establish procedures for determining qualifications of individuals for the positions." Nathan Hershey, Institutional Licensure for Health Professionals?, HOSP. PROGRESS, Sept. 1976, at 75, 75. However, such a system would limit the mobility of nondoctors from institution to institution, would not provide for the possibility of independent practice, and would allow the institution's fiscal concerns, rather than patient choice, to determine the type of practitioner to provide a particular patient's care.
\item \textsuperscript{213} An additional legal problem that arises when health care institutions try to use employees in ways that violate the medical practice acts is illustrated by O'Sullivan v. Mallon, 390 A.2d 149 (N.J. Super. Ct. Law Div. 1978). In that case, an x-ray technician alleged that she was fired from her job at a hospital because of her refusal to perform catheterizations, a procedure which, under the New Jersey Medical Practice Act, could legally be performed only by doctors and nurses. Id. at 149. The court, refusing to grant defendants' motion to dismiss the complaint, held that it would violate public policy for a hospital to fire an employee for refusal to engage in the unauthorized practice of medicine. See id. at 150.
\item \textsuperscript{214} See OTA STUDY, supra note 16, at 31.
\item \textsuperscript{215} See Group Health Plan, Inc. v. State Bd. of Registration for the Healing
the matter cannot be clarified until their employee is prosecuted.

In a number of instances where nonphysician practitioners have set up independent practices, medical licensing authorities or doctors and hospitals have worked actively to close down the practices. In Alabama, in 1977, the state nurses' association attempted to establish rural clinics offering the services of nurse midwives and nurse practitioners. Such clinics would have enhanced rural residents' access to health care since Alabama has fifty counties without obstetricians. However, the State Board of Medical Examiners took action to prohibit nurses from working in a clinic without a doctor physically present.

Forbidding alternative health care professionals from providing the services they are capable of providing makes no policy sense. Economists have already suggested the need for alternatives to the current medical licensing system. Legal commentators, too, have begun to press for changes in medical licensing as a means to assure a more rational division of labor or greater consumer choice or because they feel

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217. See id.
218. Id.
219. See, e.g., MILTON FRIEDMAN, CAPITALISM AND FREEDOM 137-160 (1962) (arguing that, while most people think that some form of licensure in the practice of medicine is desirable, any form of occupational licensure restricts individual freedom and, therefore, should be abolished). See generally AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY RESEARCH, OCCUPATIONAL LICENSURE AND REGULATION (Simon Rottenberg ed., 1980) [hereinafter OCCUPATIONAL LICENSURE AND REGULATION]. Some philanthropists are interested in funding efforts to challenge state and local licensing of professionals. See W. John Moore, Wichita Pipeline, 17 NAT'L J. 1168, 1169, 1173 (1992) (reporting that David Koch, a member of the Koch family foundations that donated about $4 million in 1990 to groups supporting its philosophies, "strongly endorses litigation to challenge state and local licensing of professionals, from beauticians to shoe-shine boys"). The Heartland Institute in 1992 published a report, Why We Spend Too Much on Health Care, which listed occupational licensure as one of the factors which inflates health care costs. See JOSEPH BAST ET AL., WHY WE SPEND TOO MUCH ON HEALTH CARE 13-14 (1993) (attributing the increased cost of health care in part to state occupational licensure laws that prevent alternative practitioners from performing routine health care functions); see also Report Blasts National Health Insurance, AIDS WEEKLY, Feb. 10, 1992, at 15 (blaming government policies such as occupational licensing for the "unnecessarily high" health care spending in the U.S.).
220. See Christoffel, supra note 178, at 64, 71-73 (discussing how licensing nonphysician medical personnel could help rationalize labor practices in health care delivery).
that the present system has constitutional defects.\footnote{222}

Because all health care falls within the definition of the practice of medicine, any service that an alternative health care provider wants to provide must be authorized by a special statutory exemption or a separate licensing law covering that type of professional. All states provide that at least a few practitioners of other professions shall not be considered to be practicing medicine if they engage in their own professions.\footnote{223} Arizona, for example, created a second medical licensing board covering homeopathic physicians.\footnote{224} Twenty states now license acupuncturists.\footnote{225}

In the past two decades, nearly all states have expanded the permissible roles for advanced practice nurses.\footnote{226} However, the resulting legislation has been “unduly restrictive and perpetually contradictory.”\footnote{227} Even when alternative providers are granted an enhanced scope of practice, their activities are often limited. In Hawaii, the practice act specifically acknowledges the patient’s right to choose an unlicensed practitioner if he or she wishes, but only in the situation where the patient is terminally ill.\footnote{228}

Additionally, many laws require alternative health care providers to practice under the supervision of a physician.\footnote{229} For example, a 1993 Missouri law, heralded as a major advance since it focused on an expanded primary care role for nurses,\footnote{230} only allowed advanced practice nurses to work in collaboration with physicians.\footnote{231} Also, physicians, who have a direct economic interest sit on the licensing boards for alternative providers, giving them control over admission requirements and standards.\footnote{232}

\footnote{222}{See Hodgson, supra note 197, at 674-89 (evaluating the various constitutional arguments against licensed practitioner statutes).}

\footnote{223}{See, e.g., Aiken & Sage, supra note 25, at 200 (“All states currently recognize the expanded capabilities of advanced practice nurses, but do so through a patchwork of legislation, judicial interpretations and advisory opinions.”).}

\footnote{224}{See ARIZ. REV. STAT. ANN. § 32-2902 (1992).}

\footnote{225}{O'Connell, supra note 8, at 72.}

\footnote{226}{See Inglis & Kjervik, supra note 175, at 197.}

\footnote{227}{Id.}

\footnote{228}{See HAW. REV. STAT. § 453-1.}

\footnote{229}{See, e.g., FLA. STAT. ANN. § 458.303(2) (West 1991).}

\footnote{230}{See Weissenstein, supra note 30, at 58. “Access and cost were two of the reasons Missouri lawmakers gave for the recent passage of [the new law].” Id. First Lady Hillary Rodham Clinton, who was present for the signing, “said the plan would fit into the ‘broad national framework’ for reform.” Id.}

\footnote{231}{See id.}

\footnote{232}{See FRIEDMAN, supra note 219, at 140 (citing WALTER GELLHORN, INDIVIDU-
Even when a separate board is created for alternative providers, the medical board may be allowed to challenge the decisions of the alternative provider board. Recently, a state medical board and a state optometry board took different positions on whether optometrists should be allowed to offer a particular treatment.233 The Oklahoma Supreme Court held that the medical board had standing to bring a declaratory judgment action against the optometry board.234 The court stated that the medical board “has the right and the duty to regulate the practice of medicine.”235

Consequently, even when statutes allow alternative providers to provide some health care services, unauthorized practice of medicine suits have been brought against alternative providers, usually at the instigation of local medical societies, when the alternative providers are perceived to have crossed over the elusive line between their profession and that of medicine. In Sermchief v. Gonzales,236 the Missouri Supreme Court considered a lower court disciplinary decision that held that nurse practitioners were “practicing medicine” by performing routine gynecological services.237 The court reversed, refusing to “draw that thin and elusive line that separates the practice of medicine and the practice of professional nursing in modern day delivery of health services.”238 Physicians, however, continue to institute unauthorized practice of medicine suits, causing alternative providers to face the costs of legal defense even when the suits are not found meritorious.239

Other statutes seem to provide big advances for alternative providers, but on closer examination are quite limited. Statutes in forty-two states and the District of Columbia allow nurse practitioners some authority to prescribe drugs.240 In 1993, at least fourteen states expanded prescription authority for nonphysicians.241 While an increasing number of states give prescriptive power to nurses, in half of the states, it is only exercisable under the supervision of a physician, and seven

AL FREEDOM AND GOVERNMENTAL RESTRAINTS (1956).
234. See id. at 500.
235. Id. at 499.
236. 660 S.W.2d 683 (Mo. 1983).
237. See id. at 684.
238. See id. at 688, 690.
239. See, e.g., Korte, supra note 84, at 56 (discussing a midwife who spent $40,000 in legal fees defending an unauthorized practice claim).
240. See Inglis & Kjervik, supra note 175, at 202.
241. Page, supra note 121, at 3.
states limit the types of drugs that may be prescribed.\textsuperscript{242} This is despite the fact that in states such as Oregon where nurse practitioners have had prescribing privileges for the past fifteen years, there has been no increase in patient complaints nor any indication of increased risks to patients.\textsuperscript{243} Lack of prescriptive power leads to duplication of services and increased costs.\textsuperscript{244} For example, a pediatric nurse practitioner in Pennsylvania can receive Medicaid reimbursement for diagnosing urinary tract infections or iron deficiency anemia in children, but state laws limit her from prescribing treatment for those conditions.\textsuperscript{245}

Similarly, as of 1992, twenty-five states required some level of direct third-party reimbursement to nurse practitioners and certified nurse midwives.\textsuperscript{246} Along those lines, the proposed Clinton health reform would have required fee-for-service plans to reimburse alternative providers.\textsuperscript{247} A federal statute requires direct Medicaid reimbursement for certified nurse midwives, pediatric nurse practitioners, and family nurse practitioners,\textsuperscript{248} but some states flagrantly disregard the law.\textsuperscript{249} In addition, the direct reimbursement laws in some states apply just to insurance companies. For example, most states mandate insurance coverage for chiropractors, but these laws do not apply to the managed care plans covering fifty-five percent of Americans.\textsuperscript{250}

\textsuperscript{242} See Inglis & Kjervik, supra note 175, at 202.
\textsuperscript{243} See Page, supra note 121, at 36.
\textsuperscript{244} Aiken & Sage, supra note 25, at 201.
\textsuperscript{245} Id.
\textsuperscript{247} The Clinton plan provided that each medical plan must cover "[s]ervices of physicians and other health professionals." THE WHITE HOUSE DOMESTIC POLICY COUNCIL, THE PRESIDENT'S HEALTH SECURITY PLAN 21 (1993). The plan also prohibited states from limiting, through licensure requirements or other restrictions, "the practice of any class of health professionals except as justified by the skill or training of such professional." Id. at 23. Additionally, the plan pledged to remove "inappropriate barriers to practice" for advanced practice nurses and physician assistants. Id. at 146.
\textsuperscript{249} For example, the Illinois Department of Public Aid will not reimburse for midwife assisted home births, even though federal officials have warned them that they are not in compliance with the law. See Letter from Charles W. Hazlett, Associate Regional Administrator, Division of Medicaid, to Mary Ann Langston of the Illinois Department of Public Aid 3 (Sept. 25, 1992) (on file with the Houston Law Review).
\textsuperscript{250} See Making Preventive Care Part of Managed Care, USA TODAY, Aug. 16, 1994, at 6D.
V. EXPANDING THE SCOPE OF ALTERNATIVE PRACTICE: THE PATIENT’S RIGHT TO CHOOSE

There are serious legal and practical limitations on the scope of practice of alternative providers, yet there are also obstacles to changing the underlying policies. Market forces have not provided consumers with the opportunity to press for expanded access to alternative providers. Because seventy-five to ninety percent of health coverage is purchased by employers on a group basis, consumers frequently do not have the choice of health plans that cover alternative providers, and there is no incentive for employers to exert pressure on health plans to include alternative providers.

The political power of the medical profession is also difficult to challenge in legislatures. Physician groups are a strong and wealthy lobbying force; the American Medical Association (AMA) has one of the largest political action committees (PACs) in the country, with many legislators on its political contribution list. In fact, the AMA was described in a 1993 article as the “undisputed king of PAC contributions”—distributing $3.2 million in the 1991-1992 election cycle. As a result, state and federal regulations give virtual monopoly privileges to physicians and deprive consumers of the benefits of alternative health care professionals. When laws are adopted to legitimate some aspect of alternative care, they often include provisions to assure that physicians still get paid by requiring “physician supervision” and still retain control by enabling the licensing board dominated by physicians to determine what the alternative providers may or may not do. Ceding control of alternative providers to physicians in this way deprives consumers and society of the benefits of

251. Berg, supra note 40, at 837.
252. Id.
253. See id. at 836 (suggesting that employers can attract and keep good employees without offering alternative care).
254. Aiken and Sage note that “political battles are currently fought in forums that favor physicians because of superior financial resources or established influence, and opportunities for collateral attack on nurses’ scope of practice through private litigation have deterred nurses from providing clinically appropriate and cost-effective care.” Aiken & Sage, supra note 25, at 202.
255. Weisssenstein, supra note 30, at 58. This compares to $658,000 from chiropractors, $401,000 from pediatricians, $398,000 from optometrists, $307,000 from nurses, and almost $200,000 from physical therapists. Id.
256. Refer to notes 177-239 supra and accompanying text (discussing the limiting effect of medical licensing laws).
257. Refer to notes 240-43 supra and accompanying text (explaining the limitations in laws that appear to expand the role of alternative care providers).
alternative practice by enhancing the cost of such services and making those services more closely resemble the physician services that consumers are rejecting.

In other fields, the U.S. Supreme Court has rejected the argument that the difficulty that clients might have in distinguishing between good and bad services justifies having providers, rather than consumers, decide who competes with whom. In the health care arena, it has been assumed that doctors and the medical licensing board should be the judges of what services should be offered by alternative providers. This assumption has been codified by laws that limit the activities done by alternative providers to situations of physician supervision or that give medical licensing boards the authority to regulate and set limits to alternative providers' scope of practice. There are now several reasons to challenge this approach.

First, physicians may not have the competence to regulate the activities of other professionals. In over a dozen states, nurses' practices are regulated at least partially by the medical boards, yet "[t]hey are not trained in nursing, they do not practice nursing, and—given the relatively recent development of advanced practice nursing—they have typically never experienced sustained practice with these providers in a variety of practice settings." Second, because physicians and alternative health care providers compete in the same market, physicians may have financial incentives to prevent alternative providers from practicing to the full extent of their capabilities. Third, the involvement of physicians may undermine

258. See FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 463 (1986) (rejecting the attempted defense that "an unrestrained market . . . will lead [dental patients] to make unwise and even dangerous choices"); National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 681 (1978) (rejecting the assertion of the National Society of Engineers that the association's canon of ethics prohibiting competitive bidding by its members was justified because it minimized the risk that competition would produce inferior engineering work that endangered the public safety).

259. Refer to notes 229-35 supra and accompanying text.


261. See id. at 449 (describing how "financial or competitive opposition" leads to "a strong possibility that anti-competitive motives will dictate restrictions that are not justified on public safety grounds"); see also Berg, supra note 40, at 818 (noting that doctors and chiropractors compete for patients in many of the same areas). Increasing attention is being paid to physician's conflicts of interest in a variety of realms, and many argue that physicians' ability to control the scope of practice of competing alternative providers should be constrained. See, e.g., MARC A. RODWIN, MEDICINE, MONEY, AND MORALS: PHYSICIANS CONFLICTS OF INTEREST 8-9 (1993) (pointing out the problems that might occur when physicians are financially motivated at the expense of patients' health and well-being); Elton Scott & Jean M. Mitchell, Ownership of Clinical Laboratories by Referring Physicians: Effects on Utilization,
the cost benefits that alternative health care professionals offer because the price to consumers obviously is higher if physician supervision is required.262

Fourth, letting the medical model dominate may create greater risk to patients because the licensing system may force people to choose a more harmful treatment approach.263 The physician practitioner may lack training in areas such as prevention, nutrition, or sexual counselling264 and thus not fully competent to handle the individual's problem. The physician practitioner may choose intrusive and harmful tests and remedies when less intrusive approaches could achieve equal or better results. For example, certain obstetrical practices during birth may be inimical to safe outcomes for women. Midwives do not require women to stay in the horizontal birth position, which makes it more difficult for the woman to push and increases the need for episiotomy.265 Instead of using anesthesia and drugs for pain, midwives use safer alternatives such as breathing techniques, walking, hot showers, warm compresses, lubricants, self-hypnosis, and massage therapy.266 Additionally, allowing physicians to "supervise" how the service is delivered may lead to dominance of the intervention-oriented medical model.267

Fifth, institutionalizing physician dominance over who

262. See Aiken & Sage, supra note 25, at 201 (stating that physician supervision duplicates services and increases health care costs).

263. Refer to notes 78-80 supra and accompanying text (suggesting that physicians frequently use unnecessary procedures). Forcing an individual to choose a harmful medical treatment when safer ones are available has been held to be a violation of the individual's right to privacy in the abortion context. In Planned Parenthood v. Danforth, 428 U.S. 52 (1976), the U.S. Supreme Court considered the constitutionality of a state statute that prohibited saline amniocentesis as a form of abortion. See id. at 58-59. The Court declared the law unconstitutional after finding that "as a practical matter, it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." Id. at 79. The same logic could be applied in declaring medical licensing laws unconstitutional to the extent that they interfere with patients' access to health care alternatives that are safer or less intrusive than medical doctors.

264. Refer to notes 74-77 supra and accompanying text (describing how nurse practitioners outscore physicians in emphasizing prevention, communication, and counseling).

265. See Beverly Larson, Childbirth in the '90s, PREVENTION, Apr. 1995, at 86, 88.

266. See id. at 90; see also Bergman, supra note 18, at 46 (indicating that midwifery deliveries achieve lower health costs, higher birth-weight rates, and lower infant mortality rates while also decreasing the need for anesthesia, episiotomies, and cesarean sections).

267. Refer to notes 74-80 supra (discussing the role of prevention in modern health care and the use of noninterventionist methods by alternative providers).
provides health care does not advance the interest of informed choice. As Simon Rottenberg points out, "The administration of licensing laws is carried out in ways that reduce the dissemination of information."268 By granting physicians a monopoly on health care services,269 the laws provide no incentive for physicians to inform people. People have no choice but to go to physicians. Because there is generally no legally authorized alternative to licensed physicians, physicians may not feel compelled to spell out the basis for, risks of, and alternatives to a specific treatment or their competence to perform the proposed treatment. Despite the existence of other specific informed consent laws, physicians actually do very little informing.270

It is time for a serious re-analysis of the state laws that privilege physicians. The laws defining the practice of medicine were drafted and passed a century ago when the most common diseases were infectious diseases,271 but significant changes have occurred in the health needs and attitudes of consumers, in the practice of medicine, and in the training of alternative providers. With the success of vaccination and the development of antibiotics, most infectious diseases are now treatable, and the major health problems are chronic diseases.272 Because of their communication skills, their accessibility in the community, and their emphasis on prevention and care, alternative providers are better suited than physicians to provide many of the necessary health care services.273 Support for these preventive approaches can alleviate the need for later costly medical interventions.274

268. Simon Rottenberg, Introduction to OCCUPATIONAL LICENSURE AND REGULA-
TION, supra note 219, at 1, 8.

269. Refer to notes 177-239 supra and accompanying text (discussing the barrier of licensing laws).


271. See Christoffel, supra note 178, at 59.

272. See PUBLIC HEALTH SERV., U.S. DEPT OF HEALTH & HUMAN SERVS., FOR A
HEALTHY NATION: RETURNS ON INVESTMENT IN PUBLIC HEALTH 41 (1994) [hereinafter
HEALTHY NATION] (noting that "o(very the past century, the profile of disease, injury, and death has changed dramatically" in that "n(ow death is most often due to the chronic illnesses of coronary artery disease, stroke, and cancer"); Knowles, supra note 33, at 57-58 (explaining how vaccinations, antibiotics, and public health and hygiene measures have decreased the incidence of infectious disease).

273. Refer to notes 74-77 supra and accompanying text.

274. See HEALTHY NATION, supra note 272, at 42 (explaining that failing to support innovative strategies for prevention increases pressure on the health care system and predicting that by the year 2000, nearly one out of every nine dollars spent on treating conditions such as stroke and coronary heart disease "could be averted
During the past twenty years, people have become increasingly interested in making their own health care decisions and are now engaging in a wider range of activities to enhance their health.\textsuperscript{275} The epidemiological changes toward more chronic diseases require that people have a greater understanding of their own health needs and a greater ability to recognize their own symptoms, seek and assess care, and carry out various treatment regimens on their own.\textsuperscript{276} As illustrated by the phenomenal growth in self-care books,\textsuperscript{277} consumers are clearly taking greater control of their health. They are asserting an interest in greater choice among health care practitioners for reasons of medical philosophy and as a way to cut health care costs.\textsuperscript{278} In Oregon and Idaho, for example, the public voted to legalize dental technicians’ ability to practice independently, despite heavily funded opposition from organized dentistry.\textsuperscript{279} People are clearly more sophisticated health care consumers than they were in past generations, and they need to be, due to not only changes in the disease picture, but also changes in a health care delivery system that has made professional services more fragmented and less affordable. Other areas of the law such as the doctrine of informed consent and the right to refuse treatment have recognized this fact by increasing patient autonomy.\textsuperscript{280}

A more patient-centered health care practice would give patients greater options to consult alternative providers. A more patient-centered legal analysis might even privilege that choice. Several commentators have suggested that the constitutional right to privacy might encompass an individual’s right to choose a treatment not currently accessible under the law.\textsuperscript{281}

\textsuperscript{275} See Safriet, supra note 37, at 449 (pointing out that consumers today “have access to more information and participate more actively in their care”).

\textsuperscript{276} See Andrews & Levin, supra note 34, at 45.

\textsuperscript{277} See Virginia E. McCollough, Want to Write for the Lay Person? Try a Self-Help Angle, AM. MED. NEWS, Mar. 7, 1994, at 50 (noting that publishers are emphasizing self-care books because of the high reader demand).

\textsuperscript{278} See Herman, supra note 13, at 10 (suggesting that a greater number of people who are frustrated with their medical treatment are turning to alternative medicine). For further discussion about the reasons people seek alternative treatment, refer to Part I supra.

\textsuperscript{279} Christoffel, supra note 178, at 79.

\textsuperscript{280} See GEORGE J. ANNAS, THE RIGHTS OF PATIENTS: THE BASIC ACLU GUIDE TO PATIENT RIGHTS 83 (2d ed. 1989) (explaining that the informed consent doctrine and the corresponding right to refuse unwanted medical treatment have “helped transform the doctor-patient relationship” by protecting the patient’s interest in bodily integrity and self-determination).

\textsuperscript{281} Some have argued, for example, that the right to privacy articulated in Griswold v. Connecticut, 381 U.S. 479 (1965) and subsequently applied in Roe v.
Already one court—the Southern District Court of Texas, in *Andrews v. Ballard*—has held that an individual's right to make health care decisions is protected by the right to privacy and includes a right to seek services from an alternative practitioner. The provision at issue in the case concerned Texas's broad definition of the practice of medicine which required that only licensed medical doctors be allowed to offer acupuncture. The plaintiffs in the case were individuals seeking services from nonphysician acupuncturists. After an extensive analysis of U.S. Supreme Court and lower court cases involving privacy and health care, the court held that "the decision to obtain or reject medical treatment, presented in the instant case as the decision to obtain acupuncture treatment, is both personal and important enough to be encompassed by the right of privacy." The court noted that "[o]ne's health is perhaps one's most valuable asset. The importance of decisions affecting it cannot be overstated."

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Wade, 410 U.S. 113 (1973), might encompass an individual's right to choose a medication and may thus provide the basis for a constitutional challenge of federal statutes that restrict this right of choice. See, e.g., Robert J. Milis, Comment, *Government Regulation of Health-Care Drugs of Questionable Efficacy*, 14 SAN DIEGO L. REV. 378, 388 (1977) ("A constitutional right to obtain and use health-care drugs of questionable efficacy might be derived from . . . a right of privacy."); Don G. Rushing, Comment, *Picking Your Poison: The Drug Efficacy Requirement and the Right of Privacy*, 25 UCLA L. REV. 577, 577-78 (1978) ("[T]he right of privacy established by the Supreme Court in *Griswold v. Connecticut* may now provide a new basis for a substantive due process challenge to federal drug regulation schemes restricting this choice." (footnote omitted)). Other commentators have focused on an individual's right to choose harmless treatments of unproven efficacy. See Hodgson, *supra* note 197, at 647-48 (discussing California's restrictions on the use of unorthodox health treatments that do not harm patients, such as naturopathy, hypnotism, and vitamin therapy).

283. See id. at 1057 ("The plaintiffs have a constitutional right, encompassed by the right of privacy, to decide to obtain acupuncture treatment.").
284. See id. at 1040.
285. See id. at 1039.
286. Id. at 1048.
287. Id. at 1047.

It is the individual making the decision, and no one else, who lives with the pain and disease. It is the individual making the decision, and no one else, who must undergo or forego the treatment. And it is the individual making the decision, and no one else, who, if he or she survives, must live with the results of that decision. . . .

. . . [I]t is impossible to discuss the decision to obtain or reject medical treatment without realizing its importance. The decision can either produce or eliminate physical, psychological, and emotional ruin. It can destroy one's economic stability. It is, for some, the difference between a life of pain and a life of pleasure. It is, for others, the difference between life and death.

*Id.*
The court found that requiring acupuncture to be performed by a licensed physician imposed a burden on and significantly interfered with the patient's fundamental right to a choice of medical treatment. The medical licensing requirement, by forcing people to seek acupuncture services from doctors, limited their access to the service and prevented them from undergoing acupuncture by those who had training and experience in the technique but no medical license. Licensed medical doctors were not trained in either the theory or practice of acupuncture, and very few even offered the procedure.

Although the State maintained that the licensing requirement was necessary to protect patients, the court said that "acupuncturists are, it cannot be gainsaid, as a class, more likely to safely and effectively administer acupuncture treatment than are the physicians currently licensed to practice medicine in Texas." Moreover, the court noted that there were more narrowly drawn means to meet the state's interest, such as requiring acupuncturists to pass courses in emergency medical treatment or to make arrangements to have medical treatment readily available to assure that patients have ready access to a physician if they need one.

Although it is unlikely that many other courts would follow the Andrews court's constitutional reasoning, the court's analysis can provide a useful policy guide for legislators. It makes sound policy sense for lawmakers to realize, as

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288. See id. at 1051.
289. See id. (noting that the plaintiff could not "find a single licensed physician in the state of Texas who was skilled in the practice of acupuncture").
290. See id.
291. See id. at 1053.
292. Id. at 1055.
293. See id. at 1055-56. The court did not limit the right to choose acupuncture to individuals for whom Western medicine offered no remedy. The court noted that "[t]he alternative Western treatment, whether drugs or surgery, may involve a serious risk of side effects or injury." Id. at 1047. The court also pointed out that it would not be advisable to require people seeking acupuncture to undergo a standard medical alternative first, particularly because research had shown that acupuncture was more effective on individuals who had not undergone surgery. Id. at 1047 & n.29.
294. The North Carolina Court of Appeals specifically rejected the Andrews court's approach. See Majebe v. North Carolina Bd. of Medical Examiners, 416 S.E.2d 404, 408-09 (N.C. Ct. App. 1992). Also, the California Supreme Court rejected the idea reasoning the right to privacy protects a woman's right to choose to give birth with the assistance of a midwife. See Bowland v. Municipal Ct., 556 P.2d 1081, 1089-89 (Cal. 1976) ("[T]he right of privacy has never been interpreted so broadly as to protect a woman's choice of the manner and circumstances in which her baby is born.").
the *Andrews* court did, that decisions about one’s health are vitally important to people, that doctors are not always the best providers of health care, and that there are more appropriate means than ceding authority to physicians to determine the appropriate scope of alternative providers’ practices.

Legislators should take several steps to gain the benefit of alternative providers while protecting against risks. First, they should limit the definitions of the practice of medicine so that they cover not all of health care, but only particularly hazardous interventions and so that they do not apply to mere “conditions.”

Second, they should provide expansive statutory definitions for other types of practice such as homeopathy, chiropractic, nurse midwifery, advanced practice nursing, lay midwifery and so forth. They should provide that, while acting within their own scope of practice, alternative providers should not be considered to be practicing medicine without a license. Such provisions should allow for independent practice, direct billing, and where appropriate, prescriptive powers.

Third, legislators should provide for separate regulatory boards for alternative providers and should not provide any role to the medical licensing board. Fourth, they should devise ways to ensure that people have adequate information about all types of practitioners regarding their training, competence, and proposed means of prevention, diagnosis, or treatment. Fifth, legislators should create policies to prevent unsafe and deceptive practices by alternative providers.

Legislators confronted with proposals for expanded practice by alternative providers may wonder if the consumer will be adequately protected. They may initially fear that people will

295. Refer to note 181 supra (listing state practice of medicine statutes that apply to “conditions”).


297. In one malpractice case, a patient received second-degree burns from an acupuncturist’s treatment and sued on the claim that he was not informed of the risk. A $15,000 settlement was expected. *See* O’Connell, supra note 8, at 74.

298. An injunction was obtained, for example, in one unauthorized-practice suit to prevent employees of a nutritional center from using the title “doctor” if they were not licensed in the state. *See Efrain Hernandez, Jr., Nutrition Center Faces Injunction, BOSTON GLOBE,* Mar. 18, 1994, at 26.
consult alternative practitioners in situations where doctors would indeed offer a benefit. However, in cultures "in which two or more systems for dealing with illness coexist, there is some evidence to suggest that people make reasoned decisions in choosing an alternative." People can recognize the differences in benefits offered by different types of health care practitioners, much as they now distinguish between dentists and doctors, or between a malady that can be helped by an over-the-counter drug and one that cannot. Additionally, professional education and the threat of malpractice actions make it reasonable to assume that most alternative providers recognize the limitations of their skills and training.

Legislators may be reluctant to try alternatives to the current licensing system for fear that alternatives will lure and take advantage of the poor and illiterate. But various analyses of the current use of alternative practitioners suggests just the opposite. It is generally the more educated and affluent consumers who choose nonphysician health care providers. Rather than being a misled group in need of protection, the people choosing alternatives are often of the same educational and economic group as the legislators themselves. Indeed, the use of nonphysicians by such a choice group of consumers may be one of the reasons organized medicine is fighting so strongly against legislative recognition and hospital privileges for alternative practitioners.

In addition to the changes needed by state legislatures, the federal government should make changes as well. The federal government expended $5.2 billion for graduate medical education in 1992. This subsidy distorts the use of providers by "mak[ing] it cheaper for hospitals to use residents to meet ongoing service needs than to employ any other kind of provider." That subsidy needs to be reconsidered in terms of how

300. Cf. Andrews v. Ballard, 498 F. Supp. 1038, 1047 (S.D. Tex. 1980) (stating that individuals must decide whether to undergo or forego treatment and that the individual must live with the results of the decision).
301. See Eisenberg et al., supra note 2, at 248 (concluding that the use of alternative therapy is significantly more common among those with a college education and those with an annual income over $35,000).
303. Id. at 198-99. "Medicare alone paid teaching hospitals over $70,000 for each resident physician during 1992." Id. at 197.
the money could be spent to assure more primary care providers such as nurse practitioners and midwives.

VI. CONCLUSION

Changing health care needs, consumer preferences, and escalating health care costs suggest that there is a role for expanded practice by alternative health care professionals. Such providers work in areas where it is difficult to attract physicians and with patients that physicians may not be interested in serving. They also offer benefits such as less interventionist approaches and greater information than physicians offer. However, the availability of the services of alternative providers is influenced by state statutes governing the practice of medicine, the scope of medical licensing boards, and reimbursement of alternative providers.304 Changes are necessary to assure that such statutes do not privilege doctors at the expense of patients.

304. See Sekscenski et al., supra note 1, at 1270 (concluding that favorable state practice environments for alternative providers "were strongly associated with a greater supply of these practitioners").