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New Health Practitioner Liability and Standard of Care: A Prediction

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I. INTRODUCTION

As an answer to the increased demand[1] for primary care[2] throughout the nation, a new kind of health care provider emerged in the late sixties.[3] Often referred to as "physician extenders"[4] or "new health professionals,"[5] these physician's assistants and nurse practitioners provide diagnostic and therapeutic treatment for patients[6] who do not otherwise have access to primary care. A physician's assistant is defined by the American Medical Association as "a skilled person qualified by *academic* and *practical* training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."[7] A physician's assistant's training requirements vary slightly from state to state. Prerequisites to entrance in a training program differ from high school diploma to two years of college level course work. Some states also prefer two to three years of health related work.[8] Once enrolled in a state Board of Education accredited training program, the physician's assistant candidate studies traditional liberal arts courses, along with non-traditional academic courses focusing on clinical (applied) medicine.[9] Graduates of accredited educational programs are then employable as physician's assistants under the direct supervision of a physician or institution.

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1. C. FUCH, WHO SHALL LIVE? (1974) and Scheffler, *Physicians and New Health Professionals—Issues for the 1980's*, INQUIRY, Fall 1979, write that although there is not a doctor shortage, there is a maldistribution of doctors with deficits in rural, inner city, and other poor areas. This maldistribution causes the demand for new primary care distributors.

2. Primary care is "initial access" and "overall management" care of a patient. *See* P. DEDMAN, ALLIED HEALTH EDUCATION DIRECTORY 370 (7th ed. 1977). Examples of primary care include receiving patients, performing or assisting in laboratory procedures, giving injections, suturing wounds, performing general physical examinations and counseling service. *Id.*

3. Chapman & Record, *Defensibility of New Health Professionals at Law: A Speculative Paper*, 4 J. HEALTH POL., POL'Y & LAW 30, 30 (1979).

4. *Id.*

5. This is the more common term of art used to categorize phyisician's assistants and nurse practitioners.

6. These patients reside in the traditional physician deficient areas. The areas include rural areas and urban poor areas. *See* Rural Health Clinic Services Act of 1977 § 1, 42 U.S.C. § 1395 (1976) [hereinafter cited as RHCSA]. Deficient areas also include state mental health or prison institutions. *See* Ramos v. Lamy, 639 F.2d 559, 577 (10th Cir. 1980).

7. *See* DEPARTMENT OF HEALTH MANPOWER, DIVISION OF MEDICAL PRACTICE, AMERICAN MEDICAL ASSOCIATION, EMPLOYMENT AND USE OF PHYSICIAN'S ASSISTANTS 5 (1973)(emphasis added).

8. *See* P. DEDMAN *supra* note 2, at 370.

9. *Id.*

A nurse practitioner is a licensed registered nurse with further special training. To prepare for licensure as a registered nurse, a student can attend "one of three types of nursing educational programs: diploma, associate degree, and baccalaureate."[10] A nursing diploma can be received after completion of a hospital based program, which is usually three years in duration.[11] "Basic nursing education provided in a 2 year community college leads to an associate degree in nursing, and that provided through a 3 year collegiate program results in a bachelor's degree in nursing."[12] Once licensed to practice as a registered nurse, an individual is eligible to become a nurse practitioner upon completion of specialized training in a state Board of Education nurse practitioner training program.

These two types of health professionals do not share statutory authorization to practice.[13] Their respective practices are governed by different statutes and are regulated by different bodies.[14] As a result, physician's assistants practice as agents of their supervisory physician or institution,[15] while nurse practitioners practice either as agents of a hiring institution or physician or as independent contractors.[16]

To help dispense primary care most effectively the new health professionals should perform in expanded autonomous practice,[17] especially in the physician deficient areas.[18] But before the new health professional can become a main source of primary care, either as an

10. FACTS ABOUT NURSING 127 (1981).

11. *Id.*

12. *Id.*

13. Washington State Nurses Ass'n v. Board of Medical Examiners, 93 Wash. 2d 117, 119, 605 P.2d 1269, 1271 (1980).

14. For a discussion of model physician's assistant authorization legislation, see Comment, *The Physician's Assistant in Michigan: A Second Look at Expanded Medical Delegation*, 1978 DET. C.L. REV. 45, 57 (1978); *See also* MICH. COMP. LAWS ANN. § 338.371 (Supp. 1983), which delegates authority for physician's assistants to practice through a supervising physician and Physician's Assistant Committee (Committee). *See* CAL. BUS. & PROF. CODE § 2513 (West Supp. 1984). The Committee approves supervision of a physician's assistant practice so that "they exercise no independent authority." Washington State Nurses Ass'n v. Board of Medical Examiners, 93 Wash. 2d at 118, 605 P.2d at 1271.

Nurse practitioner authorization comes from state registered nurse statutes. *See, e.g.*, CAL. BUS. & PROF. CODE §§ 2700-2825 (West 1974 & Supp. 1984).

Registered nurses can practice as nurse practitioners after completing a state-approved nurse practitioner training program. Nurse practitioners are regulated by the American Nursing Association (ANA).

15. Hospitals and medical clinics are the institutions where new health professionals work.

16. *E.g.*, Lane, *Promoting an Independent Nurse Practice*, 75 AM. J. NURSING 1319 (1975); Goodspeed, *The Independent Practitioner—Can it Survive?*, 14 J. PSYCHIATRIC NURSING & MENTAL HEALTH SERVICES 33 (1976). The nurse practitioner must still have limited physician contact. A hotline to a physician's office is often sufficient.

17. *See generally* Golliday, Miller, & Smith, *Allied Health Manpower Strategies: Estimates of the Potential Gains from Efficient Task Delegation*, 6 MED. CARE 457 (1973); Rivara, *Impact of the Rural Health Clinics Services Bill: A Projection*, 6 J. COMMUNITY HEALTH 103 (1980).

18. *See generally* RHCSA, 42 U.S.C. § 1395 (1976).

agent of a hospital or physician or as an independent contractor, his liability in malpractice causes of action must be established. In an age in which professional malpractice suits are the norm,[19] it is necessary to take a close look at new health professional liability before determining to what extent new health professionals can practice. "The future of physician's assistants and nurse practitioners will be shaped at least in part by whether, and on what terms, they are defensible at law."[20]

In an effort to aid future policy decisions on new health professional practice, this Comment addresses two issues. First, it must be determined who will be held liable for the malpractice of the new health professional. Will it be the new health professional himself, or, if the new health professional is an agent of the supervising physician or institution, will the supervisor be held liable under the doctrine of *respondeat superior*?

Once the liability question is discussed, this Comment examines what standard of care[21] the new health professional should be held to in a negligence cause of action. Presently, there is no clear standard of care established for these new health professionals.[22]

In developing a standard of care for the new health professionals, this Comment reaches three conclusions. First, boundaries for the standard of care must be established. The standard of care must be less than that of a physician, but high enough to ensure adequate patient primary care. The next conclusion concerns the choice between a national or similar community standard of care. The modern trend in medical malpractice suits is to hold the negligent health care provider to a national standard of care. This Comment proposes the following of the modern trend. Finally, this Comment discusses how flexible the national standard of care should be. To ensure its fair application, the standard of care should be flexible enough to accomodate the different levels and methods of care exercised by these diversely practicing physician's assistants and nurse practitioners.

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19. *See generally* Keeton, *Professional Malpractice*, 17 WASHBURN L.J. 445 (1978).

20. Chapman & Record, *supra* note 3, at 30.

21. A standard of care implicitly defines the duty owed by one to the people with whom he associates. The proposed new health professional standard of care is defined in terms of exercising the skill and knowledge acquired by the properly trained new health professional. It is hard to equate the skill and knowledge acquired by the new health professional with a duty owed by him to the primary care patient. Courts have answered this problem by holding the new health professional to an ordinary reasonable person standard in exercising this skill and knowledge. *See* Thompson v. United States, 368 F. Supp. 466 (1973).

22. Comment, *Nurse Practitioner—Here Today Gone Tomorrow?*, 6 NOVA L. J. 365, 381 (1982) [hereinafter cited as Comment, *Nurse Practitioner*]; Comment, *Medico-Legal Implications of Recent Legislation Concerning Allied Health Practitioners*, 11 LOY. L.A.L. REV. 379 (1978).

II. NEW HEALTH PROFESSIONAL MALPRACTICE LIABILITY

A. *The Threshold Question*

The threshold question in determining liability for new health professional malpractice is whether the new health professional in dispensing primary care is acting autonomously as an independent contractor or as an agent of either an institution or physician. If the new health professional is acting autonomously,[23] he will be liable for his own negligence. If there is no agency relationship, then there is no supervisor to be liable under the doctrine of *respondeat superior*. The negligent actor must be accountable for his own negligence. If, on the other hand, there is an agency relationship, both the agent new health professional and his principal supervisor, a hospital or physician, may be joined as defendants in a suit for alleged agent malpractice.[24] The principal may be held liable under the doctrine of *respondeat superior*.[25] This does not "exonerate the agent from liability."[26] He may still be liable for his own tort[27] and may have to pay the plaintiff's damage award[28] or later indemnify his employer[29] who has paid the plaintiff this sum.

B. *Determinants for Answering the Threshold Question*

Three factors aid in the determination of the new health professional liability question. The first factor is the legislative intent of state new health professional authorization statutes. The legislatures, in authorizing new health professionals to practice, intended to set parameters[30] for new health professional's practice. A statute that does not allow for autonomous practice will force the new health professional to practice under an agency relationship with a physician or institution,[31] while a broad delegatory statute may allow for autonomous new health professional practice.

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23. *See supra* note 16 and accompanying text.

24. *See generally* Fein v. Permanente Medical Group, 121 Cal. App. 3d 135, 175 Cal. Rptr. 177 (1981); Truhitte v. French Hosp., 128 Cal. App. 3d 332, 180 Cal. Rptr. 152 (1982); Washington State Nurses Ass'n v. Board of Medical Examiners, 93 Wash. 2d 117, 605 P.2d 1269 (1980).

25. *See* Robbins v. Footer, 553 F.2d 123 (D.C. Cir. 1977).

26. Perkins v. Blauth, 163 Cal. 782, 787, 127 P. 50, 52 (1912). *See also* RESTATEMENT (SECOND) OF AGENCY §§ 343, 344-351 (1958).

27. *See* Bayuk v. Edson, 236 Cal. App. 2d 309, 320, 46 Cal. Rptr. 49, 56 (1965).

28. REPORT OF THE SECRETARIES COMMISSION ON MEDICAL MALPRACTICE (DHEW Pub. No. (05)) 73-79 app. (1973).

29. *Id.*

30. Parameters for practice are set by *delegatory and regulatory* legislation. *See* Comment, *supra* note 14, at 57-72.

31. Virtually all physician's assistant authorization statutes are this type. *See generally id.* at 47.

There are generally two types of authorization statutes.[32] Simple authorization statutes require the new health professional to be an employee (an agent) of a supervising (and thus regulating) physician or institution. Regulatory statutes, on the other hand, require a regulatory agency[33] to define the scope of new health professional liability. Under a regulatory statute[34] a new health professional may be accorded independent prescriptive authority.[35] With this granted authority a "substantial number of nurse practitioners . . . have been experimenting with solo or group practices in which they are self-employed."[36] This is especially true in the rural areas where nurse practitioners are encouraged to operate autonomously under the Rural Health Clinic Services Act (RHCSA).[37] Here the nurse practitioner will be independently liable for any negligence.

Nurse practitioner authorization statutes may instead be simple authorization statutes.[38] Virtually all physician's assistant authorization

32. *See* Kissam, *Physician's Assistant and Nurse Practitioner Laws: A Study of Health Law Reform*, 24 U. KAN. L. REV. 1 (1975); *See also* Comment, *Nurse Practitioner*, *supra* note 22, at 370.

33. These regulatory agencies are typically the state Board of Medicine for physician's assistants and state Board of Nursing for nurse practitioners.

34. Examples of nurse practitioner regulatory statutes (a term of art) include DEL. CODE ANN. tit. 24, § 1902 (1975); GA. CODE ANN. §§ 84-1001, -1001(a) (1979) (current version at § 43-26-1 (1982)); HAWAII REV. STAT. § 457-2 (1976); ILL. ANN. STAT. ch. 111, § 3405 (Smith-Hurd Supp. 1983); MICH. COMP. LAWS ANN. § 333.17210 (1980); MO. ANN. STAT. § 335.016 (Vernon Supp. 1981); MONT. CODE ANN. § 37-8-102(3)(a) (1981); OHIO REV. CODE ANN. §§ 4723.01, -.06 (1977); OKLA. STAT. ANN. tit. 59, § 567.3 (West 1981); R.I. GEN. LAWS § 5-34-1 (1976); TENN. CODE ANN. § 63-7-2.07(13) (1982); TEX. REV. CIV. STAT. ANN. art. 4513 (Vernon 1982); W. VA. CODE § 30-7-1 (1980); WIS. STAT. ANN. § 441.01 (West Supp. 1981).

35. *See* ORE. REV. STAT. §§ 678.375-.390 (1981); WASH. REV. CODE ANN. § 18.88.030 (Supp. 1983); UTAH CODE ANN. §§ 58-31.4 to -31.9.1; N.H. REV. STAT. ANN. § 326-B:7 (Supp. 1981); "where nurse practitioners work 'in collaboration with' rather than 'under the direct supervision of' physicians." Comment, *Nurse Practitioner*, *supra* note 22, at 375. *See also* Rivara, *supra* note 17, at 105, where the author states that "[t]he Family Nurse Practitioner Council of the American Nurses Association maintains that the nurse is an independently licensed practitioner, and therefore, the relationship between the nurse practitioner and physician should be a collaborative one."

36. Chapman & Record, *supra* note 3, at 33.

37. H.R. Rep. No. 95-548, Part II, 95th Cong., 1st Sess. 9, *reprinted in* 1977 U.S. CODE CONG. & AD. NEWS 4055, 4073.

38. ALA. CODE § 34-21-1 (1975); ALASKA STAT. § 08.68.410(8)(1982); ARIZ. REV. STAT. ANN. §§ 32-1601 to -1661 (1956 & Supp. 1972-82); ARK. STAT. ANN. §§ 72-746(e), 754(f), -756.1 (1979 & Supp. 1983); FLA. STAT. § 464.012 (1981); IDAHO CODE § 54-1402 (1979); IND. CODE ANN. § 25-23-1-1(c) (Burns 1982); IOWA CODE § 152.1 (Supp. 1981); KAN. STAT. ANN. § 65-1113 (1980); KY. REV. STAT. § 314.011 (Supp. 1982); LA. REV. STAT. ANN. § 37.913 (West Supp. 1983); ME. REV. STAT. ANN. tit. 32, § 2102 (1964); MD. HEALTH OCC. CODE ANN. §§ 7-305 to -504 (1981 & Supp. 1982); MASS. GEN. LAWS ANN. ch. 112, § 80B-C (West 1983); MISS. CODE ANN. § 73-15-5 (Supp. 1982); NEB. REV. STAT. §§ 71-1, 132.05 (1981); NEV. REV. STAT. § 632.010 (1979); N.H. REV. STAT. ANN. § 326-B:2 (Supp. 1981); N.C. GEN. STAT. § 90-171.20 (Supp. 1983); N.D. CENT. CODE § 43-12.1-05 (1981); OR. REV. STAT. §§ 678.375, .380, .385, .390 (1981); PA. STAT. ANN. tit. 63, § 212 (Purdon Supp. 1983-84); S.C. CODE ANN. § 40-33-10 (Law Co-op. 1977); S.D. CODIFIED LAWS ANN. §§ 36-9A-1 to -12 (Supp. 1982); UTAH CODE ANN. §§ 58-31a-1 to -6 (Supp. 1983); VT. STAT. ANN. tit. 26, § 1572 (Supp. 1983); VA. CODE § 54-367.2 (1982); WASH. REV. CODE ANN. § 18.88.030 (Supp. 1983-84); WYO. STAT. § 33-21-120 (Supp. 1983); *see also* Trandel-Korenchuk

statutes are simple authorization statutes.[39] Consequently, some nurse practitioners and almost all physician's assistants are liable only as agents of the hiring institution or physician. Although both the agent and his principal are liable for the negligent act of the agent new health professional, the new health professional is often judgment proof.[40] The principals of the agent new health professionals usually are not.[41] Because the principal, here a physician or hospital, is the one joined defendant often capable of compensating the plaintiff,[42] it is important to know exactly who the new health professional's principal is at the time of the alleged malpractice.

Physician's assistants and nurse practitioners practicing under simple authorization statutes are often the agent of an institution in one instance and the agent of a physician in another instance.[43] A general rule of the law of agency has developed to help determine the principal for whom the agent new health professional is acting at the time of new health professional malpractice. The "borrowed servant doctrine"[44] states that:

> When an employer—the 'general' employer—lends an employee to another employer [and relinquishes to a borrowing employer] all rights of control over the employee's activities, a 'special employment' relationship arises between the borrowing employer and the employee. During this period of transferred control, the special employer becomes solely liable under the doctrine of respondeat superior for the employee's job related torts.[45]

The courts have adopted an ad hoc approach in determining whether the assistant new health professional was a temporary employee, looking to the extent of control by the borrower and the particular function of the assistant.[46]

& Trandel-Korenchuk, *Current Legal Issues Facing Nursing Practice*, 5 NURSING AD. Q. 37 (1980); Kissam, *supra* note 32, at 25 n.168.

39. *See* Washington State Nurses Ass'n v. Board of Medical Examiners, 93 Wash. 2d at 119, 605 P.2d at 1271. *See, e.g.*, CAL. BUS. & PROF. CODE §§ 3500-353.5 (West Supp. 1984).

40. *See* Comment, *The Negligent Nurse: Rx for the Medical Malpractice Victim*, 12 TULSA L. J. 104, 120 n.92 (1976) (where the author describes the low average salaries of nurses). Nurses also have a hard time finding adequate malpractice insurance coverage. *See id.* at 125 n.109. The autonomous nurse practitioner would have at least an equally tough time finding malpractice insurance coverage. Nurse practitioner average salaries are similar to those of a registered nurse. (Information acquired through interview with Dr. Mary Mundinger, Director of Graduate Programs, School of Nursing, Columbia University. (Jan. 1983)).

41. The principals here are either physicians or hospitals.

42. Hospitals and physicians have easy access to medical malpractice insurance coverage.

43. The new health professional employed by a hospital may receive patients in a hospital *emergency room* and later assist a particular physician in the *operating room*.

44. *See generally* Marsh v. Tilley Steel Co., 26 Cal. 3d 486, 606 P.2d 335, 162 Cal. Rptr. 320 (1980).

45. *Id.* at 492, 606 P.2d at 358-59, 162 Cal. Rptr. at 323-24.

46. *See* Truhitte v. French Hosp., 128 Cal. App. 3d 332, 347, 180 Cal. Rptr. 152, 159 (1982). The court here cites Hallinan v. Prindle, 17 Cal. App. 2d 656, 661-62, 62 P.2d 1075, 1077 (1936) for

The second factor in the determination of the new health professional liability question is federal legislation authorizing new health professional independent practice. The RHCSA authorizes employment of physician's assistants and nurse practitioners in rural and urban poor areas at "satellite clinics without onsite physician supervision."[47] Because a physician's assistant practicing under state simple authorization statutes[48] must have a supervising physician or institution,[49] the RHCSA has effectively reduced the supervision requirement for physician assistant practice. Nurse practitioners practicing under similar state simple authorization statutes are also subject to reduced supervision requirements under the new federal law. These previously supervised new health professionals approach autonomous practice under the RHCSA. With this autonomous practice comes independent liability.

A final factor in the new health professional agency/autonomy determination is the agent or independent contractor status of similar health care providers. Health care providers similar to the new health professionals perform similar medical functions after completing similar training requirements. For instance, the clinical technician has a medical function[50] and training requirements[51] similar to those of a physician's assistant. A clinical technician practices as an agent of a medical laboratory. He does his work under the direct supervision of a laboratory supervisor. The laboratory is liable for the clinical technician's negligence under the doctrine of *respondeat superior*.[52] A clear analogy can be drawn from the clinical technician's practice to help establish physician's assistant practice as that of an agent of a physician or institution.

An analysis of the nurse practitioner's similar health care providers' standards of care does not, at first glance, allow for a clear analogy to be drawn to a nurse practitioner standard of care. One health care provider similar to the nurse practitioner,[53] the nurse anesthetist, practices

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the proposition that a "surgeon is not liable as a special employer for negligent acts of a nurse performed while not under the surgeon's *direct* supervision and control" (emphasis added). Here the nurse's unsupervised activity was pre-operation preparation of a patient.

47. Rivara, *supra* note 17, at 103 (emphasis added).

48. *See supra* note 39 and accompanying text.

49. *See supra* text accompanying notes 7-16.

50. Both physician's assistants and clinical technicians perform technical primary care.

51. *See* P. DEDMAN *supra* note 2, at 222, where the clinical technician program entrance requirements are described as equal to most state physician's assistant program entrance requirements. Physician's assistant program curriculum have more liberal arts classes but the main focus is on clinical (applied) medicine. *See id.* at 370 for discussion of the clinical technician training program.

52. *See* Morrison v. MacNamara, 407 A.2d 555 (D.C. 1979).

53. Both nurse anesthetists and nurse practitioners are registered nurses with specific further training.

as an independent contractor.[54] The nurse anesthetist posses responsibilities that "lie in an area of expertise in which some physicians receive full residency training."[55] The hospital employs the nurse anesthetist to perform the specific function of anesthetizing the patient. Common nurse anesthetist practice is to administer the anesthesia without the operating surgeon's supervision.[56] The operating surgeon may not be held liable for nurse anesthetist malpractice under the "borrowed servant doctrine"[57] because there is no "special employment"[58] relationship between the nurse anesthetist and the operating surgeon. The nurse anesthetist is thus liable for his or her own negligence.

Another health care provider similar to the nurse practitioner, the registered nurse,[59] is, as a general rule,[60] liable for his or her negligence as an agent of the hiring physician or institution.[61] Registered nurses are hired to perform ministerial functions[62] for their principals. They are not practicing autonomously and thus are not independently liable for their negligence.

The registered nurse, although licensed under the same regulatory scheme as a nurse practitioner, does not have the advanced training necessary for autonomous practice. The nurse anesthetist does have this advanced training and exercises those skills in an autonomous setting. An analogy should be drawn from the nurse anesthetist practice to help establish nurse practitioners as autonomous when the state authorization statutes allow for such autonomy.

Clearly, the nurse practitioner is potentially the more autonomous of the two new health professionals analyzed. The nurse practitioner has the option, under some regulatory statutes, to act independently of direct supervision. The physician's assistant must practice as an agent under direct supervision, except when practicing in rural or urban poor areas under the RHCSA. Only then does the physician's assistant practice approach the autonomy the nurse practitioners exercise under reg-

54. *See* Whitney v. Day, 100 Mich. App. 707, 709, 300 N.W.2d 380, 382 (1980); Gore v. United States, 229 F. Supp. 547, 549 (E.D. Mich. 1964).

55. *Whitney*, 100 Mich. App. at 709, 300 N.W.2d at 382.

56. *Gore*, 229 F. Supp. at 549.

57. *See supra* notes 44-45 and accompanying text.

58. *Id.*

59. Nurse practitioners are similar to registered nurses in that both must meet basic entry level licensure requirements, and nurse practitioners are nurses with advanced training.

60. Before the demise of the charitable immunity doctrine, a registered nurse could be held independently liable for her negligence on a theory that plaintiffs should be compensated for their injuries by someone. *See* Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957). Under the charitable immunity doctrine non-profit hospitals were not subject to tort liability. The registered nurse was the only defendant who could be held liable for her negligence. *See* Hallinan v. Prindle, 17 Cal. App. 2d 656, 62 P.2d 1075 (1936).

61. *See* Rice v. California Lutheran Hosp., 27 Cal. 2d 296, 303-04, 163 P.2d 860, 863-64 (1945); Beaches Hosp. v. Lee, 384 So. 2d 234, 237 (Fla. Dist. Ct. App. 1980).

62. *See* Beaches Hosp. v. Lee, 384 So. 2d at 237.

ulatory statutes. With this new health professional autonomy comes independent liability.[63]

III. THE NEW HEALTH PROFESSIONAL STANDARD OF CARE

Once it is determined who is liable for the new health professional malpractice, it is necessary to establish what standard of care these new health professionals are to be held in determining their negligence.[64] Because the number of practicing new health professionals is small and their practices are diverse,[65] a clear standard of care has yet to be established.[66] In developing a standard of care three determinations must be made.

A. *Upper and Lower Bounds for New Health Professionals' Standard of Care*

The first step in establishing a standard of care is to set parameters for the standard. To determine the upper boundary of a new health professional standard of care, it must be determined whether new health professionals are in a profession distinct from physicians, and thus have their own standard of care, or are "surrogates for physicians and therefore obligated to perform at the level of physician's standard of care."[67] One proposal is to hold these new health professionals to a physician's standard of care under the theory that they are in fact dispensing *medical treatment*. As a general rule an individual undertaking to practice medicine is held to the standard of a physician.[68] But, *prescribed* new health professional practice does not include dispensing *medical treatment*.[69] They provide *diagnostic* and *therapeutic* treatment, not the independent medical judgment a physician provides.[70] Thus, a new health professional should be held to a physician's stan-

63. Another possibility, one that some courts have mentioned in dicta, is that the new health professional and his employer may be held jointly and severally liable. *See* Green v. United States, 530 F. Supp. 633, 643 (E.D. Wis. 1982); Nixon v. Riverview Hosp., 254 Cal. App. 2d 364, 376, 62 Cal. Rptr. 379, 388 (1967).

64. This determination is state substantive law. When this question comes up in federal court, state law applies to the issue of a new health professional standard of care. *See generally* Wright v. United States, 507 F. Supp. 147, 151 (E.D. La. 1981).

65. *See* Comment, *Nurse Practitioner*, *supra* note 22, at 381.

66. *See supra* note 22 and accompanying text.

67. Chapman & Record, *supra* note 3, at 33.

68. *See* Brown v. Shyne, 242 N.Y. 176, 151 N.E. 147 (1926).

69. *See generally* Fein v. Permanente Medical Group, 121 Cal. App. 3d 135, 175 Cal. Rptr. 177 (1981). While new health professionals dispense primary care diagnosis and treatment, they do not exercise independent medical judgment. If a problem requiring medical judgment arises, the new health professional can either refer the patient to a physician or follow well-defined protocols or algorithms. *See* Comment, *supra* note 14, at 66. These protocols are lists, compiled by physicians, that match patient symptoms with proposed treatment.

70. The physician with his advanced training does not have to rely on protocols or algorithms when making medical judgments.

dard of care only if he acts outside his prescribed practice.[71] Because these new health professionals have training requirements quite different from those of a physician,[72] they cannot be considered "surrogates" for the physician. They are in a profession distinct from physicians and have their own standard of care, below that of a physician.[73]

Although it is clear that the new health professional will not ordinarily be held to a physician's standard of care, there should be a certain level of care the new health professional must always provide. This minimum level of care is set by the health care provider's "duty of protection."[74] This duty owed by the new health professional assures the patient adequate health care[75] by requiring the health care provider to "exercise such reasonable care toward a patient as his known condition may require."[76] The California Supreme Court in *Rice v. California Lutheran Hospital*[77] stated that the duty must be exercised in accordance with "the illness of the patient and incidents thereof."[78] In *Rice* a health care provider was negligent for leaving a cup of hot tea on the bedside table of a weak, drugged, and hungry elderly woman. "The jury could have inferred that she would have a craving for the tea, and would, in a view of the circumstances, underestimate her strength and ability to handle the hot water."[79] Thus, the health care provider was liable for the burn injuries that resulted when the tea spilled on the patient. He had failed to fulfill his duty to protect the patient.

The new health professionals' ability to fulfill their duty to protect is assured through their authorization process. Before a licensed registered nurse can practice as a nurse practitioner she must complete a state Board of Education certified nurse practitioner training pro-

71. The new health professionals may be held liable for failing to recognize their practicing limitations. *See* Cooper v. National Motor Bearing Co., 736 Cal. App. 2d 224, 288 P.2d 581 (1955).

72. Physician training includes an undergraduate degree as a prerequisite to four years of medical school and at least three more years of residency training. Not all state new health professional training programs require an undergraduate degree as a prerequisite to enrollment. Once enrolled, the training programs last a maximum of two years.

73. *See generally* Policheck v. United States, 535 F. Supp. 1261, 1269 (E.D. Pa. 1982), where the court concluded that physician's assistants have considerably less training than physicians and cannot be expected to recognize all textbook symptoms. *See also Fein*, 121 Cal. App. 3d at 160, 175 Cal. Rptr. at 192, where the California court stated that the role of the nurse practitioner and physician differ. Thus, the jury instruction that a nurse practitioner is to be held to the standard of a physician was erroneous.

74. *See* Wood v. Samaritan Inst., 26 Cal. 2d 846, 847, 161 P.2d 556, 557 (1945).

75. *See generally* Darling v. Charlestown Community Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

76. *See Wood*, 26 Cal. 2d at 851, 161 P.2d at 558.

77. 27 Cal. 2d 296, 163 P.2d 860 (1945).

78. *Id.* at 302, 163 P.2d at 864.

79. *Id.*

gram.[80] The physician's assistant candidate must complete a similarly certified physician's assistant training program before she is authorized to practice as a physician's assistant.[81] Each state's Board of Education will assure an adequate training of the new health professionals so that they may fulfill their duty to protect the patient.

B. *National or Similar Community Standard of Care*

Once the parameters for a new health professional standard of care have been established, the next step is to choose between a national or similar community standard of care. There are three sources to examine when making this decision. First, one must look to the general trend in medical malpractice suits. Courts have consistently recognized two factors in support of a national standard of care for health professionals.[82] For one, health practitioners are becoming nationalized through a system of national board certification.[83] National board certified physician specialists,[84] general practitioners,[85] hospitals,[86] and clinical technicians[87] have all been held to a national standard of care under this theory. More importantly, the rationale for the similar community standard of care no longer exists.[88] The similar community standard of care rule was designed to protect rural practitioners who did not have access to the continuing medical education that practitioners have in metropolitan areas.[89] Present transportation and communication systems in this country lend support to the conclusion that "any purposeful disparity between the skills of practitioners in various . . . centers has for the most part been eliminated."[90] Without the disparity between the skills of practitioners from different communities, the similar community standard of care acts only as a barrier to plaintiff recovery.[91] There is no practical logic for its application in medical malpractice causes of action.

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80. *See supra* note 8.

81. *See supra* note 7.

82. *See* Morrison v. MacNamara, 407 A.2d 555, 564 (D.C. 1979).

83. *Id.*

84. *See* Robbins v. Footer, 553 F.2d 123 (D.C. Cir. 1977) (where an obstetrician, nationally board certified, was held to a national standard of care).

85. *See* Pederson v. Dumonchel, 72 Wash. 2d 73, 431 P.2d 973 (1967) (where a general practitioner was held to a national standard of care under the theory that he, along with all other general practitioners, graduated from an AMA nationally accredited medical school).

86. *See* Dickinson v. Mailliard, 175 N.W.2d 588 (Iowa 1980).

87. Morrison v. MacNamara, 407 A.2d 555 (D.C. 1979).

88. *Id.* at 563.

89. *Id.* at 561-62.

90. *Id.* at 563.

91. To establish health practitioner negligence the plaintiff patient must establish a duty owed to him by the health practitioner. He must then show that this duty was breached. This two step process often requires the testimony of an expert medical witness. If the medical practitioner

A second determinant in the choice between a national or similar community standard of care for the new health professional is established standards of care for similar health care providers. The clinical technician, similar to the physician's assistant,[92] is held to a national standard of care.[93] The same reasons which justify the application of a national standard of care to physicians and institutions appear to apply with equal validity to technicians working in medical laboratories.[94] "The opportunities for keeping abreast of medical advances that are available to doctors are equally available to [clinical technicians working in] clinical laboratories."[95]

The physician's assistant should be held to a national standard of care like his similar health care provider, the clinical technician. The physician's assistant may be nationally certified[96] and thus have nationalized standards.[97] More importantly, the training of physician's assistants is closely monitored[98] and constantly updated.[99] Consequently, there should be no disparity of skill among the different communities. Therefore, the physician's similar community standard of care is inapplicable to the physician's assistant.[100]

The nurse practitioner, unlike its similar health care providers, should be held to a national standard of care. The nurse anesthetist and registered nurse, similar to the nurse practitioner,[101] are both held to a similar community standard of care because they are rarely nationally certified.[102] Although nurse practitioners usually are not nationally

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is held to a similar community standard of care, the medical witness must be from that community in order to testify about the duty owed (standard of care) in that community.

It is difficult to find an expert who will testify against someone from his same occupation and community. This phenomenon is known as the "conspiracy of silence." *See generally* Robbins v. Footer, 553 F.2d 123 (D.C. Cir. 1977).

92. *See supra* notes 50-51 and accompanying text.

93. *See Morrison*, 407 A.2d at 565.

94. *Id.*

95. *Id.*

96. Most states do not *license* physician's assistants to practice. A few states *certify* physician's assistants. *See* CAL. BUS. & PROF. CODE § 3517 (West Supp. 1984). Because most states have no other form of accreditation, the optional physician's assistant national certification may become mandatory. *See* P. DEDMAN, *supra* note 1, at 370. (This possibility was brought to my attention through an interview with Dr. Mary Mundinger, Director of Graduate Programs, School of Nursing, Columbia University (Jan. 1983)).

97. *See supra* note 82 and accompanying text.

98. *See* CAL. BUS. & PROF. CODE § 3513 (West Supp. 1984).

99. *Id.*

100. *See supra* notes 74-78 and accompanying text.

101. *See supra* notes 53-62 and accompanying text.

102. For nurse anesthetists, *see* Whitney v. Day, 100 Mich. App. 707, 300 N.W.2d 380 (1980); Carlsen v. Javurek, 526 F.2d 202 (8th Cir. 1975).

For registered nurses, *see* Cooper v. National Motor Bearing Co., 136 Cal. App. 2d 229, 288 P.2d 581 (1955); Fraijo v. Hartland Hosp., 99 Cal. App. 3d 331, 160 Cal. Rptr. 246 (1979); Thompson v. United States, 368 F. Supp. 466 (W.D. La. 1973); Baur v. Mesta Machine, 405 Pa. 617, 176 A.2d 684 (1961).

certified,[103] their training programs offer modern instruction, including continual clinical work.[104] Because nurse practitioners across the country have equal access to the medical background pertinent to their profession, it is not necessary to hold the nurse practitioner to a similar community standard of care.[105]

A final determinant in the national or similar community standard of care choice is the Restatement Second of Torts,[106] which states the general professional standard of care: "exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in *similar communities*."[107] The Restatement is inconsistent with the modern trend in medical malpractice suits. This is not a problem, because the Restatement is only a guideline, and for the purposes of this issue, an outdated guideline. The Restatement was last revised in 1965 when the trend toward a national standard of care for the health practitioners was only beginning. This trend should be followed when developing a standard of care for the new health professionals.

C. *Flexible vs. Rigid Standard of Care*

To adopt the traditional national standard of care[108] for the new health professionals would cause inherent inequities in overall new health professional practice. Nurse practitioners, for example, are currently employed in small numbers at diverse practices.[109] Some are acting autonomously[110] while others work under the direct supervision of physicians or institutions,[111] depending on each nurse practitioner's particular state authorization statute. Because these nurse practitioners

103. Nurse practitioners are licensed by the state as registered nurses and further trained in state Board of Education approved programs. There is no state certification for nurse practitioners. The national certification available is not necessary because the nurse practitioner has been accredited through state licensure. National certification shows excellence and allows for interstate nurse practitioner mobility. (This information was acquired from Dr. Mary Mundinger, Director of Graduate Programs, School of Nursing, Columbia University (Jan. 1983)).

104. *Id.*

105. A nurse practitioner similar community standard of care would not only be inconsistent with the modern trend towards a national standard of care for medical practitioners, but would almost certainly lead to "a conspiracy of silence" among the medical practitioners in the nurse practitioner's community. *See supra* note 91. The nurse practitioners have been used sparingly. *See*, Comment, *Nurse Practitioner, supra* note 22, at 381. The experts capable of testifying against nurse practitioners advocate the nurse practitioner movement. It is hard to forsee these proponents of the nurse practitioner movement contributing to the potential demise of the nurse practitioner program by holding themselves out as expert witnesses willing to testify against nurse practitioners in malpractice proceedings.

106. RESTATEMENT (SECOND) OF TORTS § 299A (1965).

107. *Id.* (emphasis added).

108. A traditional national standard of care holds *all members of the profession* to the same level of exercised skill and knowledge.

109. *See supra* note 65 and accompanying text.

110. *See supra* note 16 and accompanying text.

111. *Id.*

are dispensing different levels of primary care a flexible nurse practitioner standard of care is necessary.[112]

The Restatement Second of Torts[113] offers guidance in establishing a flexible standard of care. When "different methods are followed by different groups engaged in a trade, the actor is to be judged by the professional standards of the group to which he belongs."[114] The utility of this standard is illustrated in *Bauer v. Mesta Machine*,[115] a case involving the negligence of a registered nurse in an industrial dispensary. The Pennsylvania Supreme Court stated the registered nurse's standard of care to be that of a "reasonably prudent registered nurse in charge of an industrial dispensary."[116] The nurse was held to a standard established by other industrial dispensary nurses, not to a standard established by all diversely practicing registered nurses within the community. Although this flexible standard of care is a similar community standard of care for certain registered nurses, it provides the courts with an equitable national standard of care to which the new health professionals are held in a negligence cause of action.[117] The autonomous new health professionals throughout the nation could set their own standard of care, independent of the standard set by the non-autonomous (agent) new health professionals.[118]

IV. CONCLUSION

New health professionals have been used sparingly to dispense primary care in physician deficient areas.[119] Studies indicate that there is an increased need for their services.[120] However, before the new health professionals can become a main source of primary care, either as

112. This flexible national standard of care is equally applicable to physician's assistants. They may not need the flexible standard of care. Because physician's assistant authorization legislation is narrow, physician's assistants do not have diverse practices except when practicing outside direct supervision under the RHCSA. *See supra* notes 43-49 and accompanying text.

113. RESTATEMENT (SECOND) OF TORTS § 299A comment f (1965).

114. *Id.*

115. 405 Pa. 671, 176 A.2d 684 (1961).

116. *Id.* at 674, 176 A.2d at 688.

117. The Pennsylvania court could only hold the registered nurses to the flexible *similar community* standard of care because registered nurses are held to a similar community, not national, standard of care. *See supra* note 102 and accompanying text. The same reasons which justify the application of a flexible similar community standard for registered nurses appear to validate a flexible national standard for new health professionals. These diversely practicing new health professionals should not all be held to the same national standard.

118. There will, in practice, be more than just two groups of new health professionals throughout the nation. For example, not all autonomous nurse practitioners will perform at the same level of autonomy. Some nurse practitioners will have easy access to physician advice and should use it. Others will have very limited access to physician advice and will be forced to rely on protocols and algorithms. *See supra* note 69.

119. *See supra* note 65 and accompanying text.

120. *See supra* note 1 and accompanying text.

agents of an institution or physician or as independent contractors, their liability and the appropriate standard of care must be determined. The liability question is answered by agency law. If the new health professional is not practicing in an agency relationship, he will be liable for his own torts as an independent contractor. If there is an agency relationship, the new health professional's principal becomes liable for the new health professional's torts under the doctrine of *respondeat superior*.

The standard of care proposed by this Comment allows for great flexibility in new health professional practice, yet assures the patient an adequate minimum level of health care and recourse if the new health professional does not provide this level of care.[121] With a well-defined new health professional standard of care, physicians, hospitals, and the new health professionals can make informed decisions on new health professional practice.

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121. The plaintiff patient does not have to face the "conspiracy of silence" inherent in a similar locality standard of care. *See supra* note 91.

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