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CROSSING THE QUALITY CHASM: AUTONOMOUS PHYSICIAN EXTENDERS WILL NECESSITATE A SHIFT TO ENTERPRISE LIABILITY COVERAGE FOR HEALTH CARE DELIVERY

Thomas R. McLean[†]

I. INTRODUCTION

IN LATE 1999, the Institute of Medicine set off a media feeding frenzy over medical errors with its public assertion that health care providers kill almost 100,000 people each year. Fifteen months latter in a much less publicized report, the Institute of Medicine offered its solutions for the carnage associated with health care delivery. *Crossing the Quality Chasm: A New Health Care System for the 21st Century* recommends that our nation jettison the traditional health care system by amending state professional board enabling statutes to liberalize the utilization of physician extenders, who will be protected from liability by enterprise liability. The purpose of this article is to stimulate discussion on this comprehensive plan to overhaul our health care delivery system.

Part II provides an overview of our health care delivery system vis-à-vis the Institute of Medicine's recent reports. Part III reviews the authority for state professional boards. While state licensure laws do limit multidisciplinary medical practice

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by granting physicians hegemony over physician extenders, changing this system will be difficult because medicine is regulated at the state rather than federal level. Removal of the patchwork system of state licensure laws and scope of practice laws will be difficult, but it is possible to remove this barrier by using conditional federal funds. Part IV looks at the nature of physician extenders and how and why the law traditionally holds such health care providers to a lower standard of care than it has traditionally held physicians. Consequently, solely shifting health care delivery from a physician-based to a physician extenders-based system of health care—in order to create a multidisciplinary health care delivery system that is more effective and responsive to the needs of patients and more cost efficient—from a legal perspective, would provide an unequivocal incentive to lower the quality of health care delivery. Part V examines the proposed alternative liability coverage systems of enterprise liability. Conceptually, enterprise liability would provide that a business organization that provided negligent medical care would bear the professional liability for compensating patients injured by that care, regardless of the training and qualification of the health care provider that injured the patient. Enterprise liability for health care delivery would be analogous to product liability for manufactured goods. Enterprise liability would, thus, provide pecuniary incentives to the health care business organizations to supervise physician extenders and, in essence, for the first time, make a negligent physician extender as liable as a negligent physician. Accordingly, if America (or a state government) liberalizes the scope of practice for physician extenders to provide for multidisciplinary health care delivery, then enterprise liability must supplant traditional malpractice liability to counteract the financial incentives of allowing highly technical health care to be delivered by individuals with a lower level of education and experience than the traditional physician.

II. OVERVIEW

The Institute of Medicine's *Crossing the Quality Chasm: A New Health System for the 21st Century* begins with a clear manifesto: "The American health care delivery system is in

need of fundamental change.”¹ Coming in the wake of the Institute’s *To Err Is Human: Building a Safer Health System*, which reported that up to 98,000 Americans die each year from errors in our health care system,² *Crossing the Quality Chasm* is a “call for action to improve the [quality of the] American health care delivery system as a whole.”³ Despite the fact that health care expenses cost America over a trillion dollars a year,⁴ the Institute of Medicine observes that “more than 70 publications in leading peer-reviewed journals have documented serious quality shortcomings.”⁵ In short, *Crossing the Quality Chasm* confirms the previous assertion that the Institute of Medicine’s recent concern over the incidence of medical errors was a mere pretext and political spin. The real message of *To Err is Human* was in the subtext: health care delivery needs to be revolutionized to be affordable.⁶

Politicians and pundits have come to a realization that the quality of health care delivery is inexorably linked to the method of payment.⁷ According to the Institute of Medicine, the perverse payment incentives of fee-for-service and managed care medicine have resulted in three types of poor quality care: overuse, underuse, and misuse.⁸

¹ COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 1* (2001) [hereinafter *QUALITY CHASM*]. The timing of the release of this report is interesting. Being released one month into a new presidency, the report was undoubtedly intended to be a message to the new administration.

² COMM. OF QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1* (Linda T. Kohn et al. eds., 2000) [hereinafter *TO ERR IS HUMAN*]; see also Elmer V. Villanueva & Jeremy N. Anderson, *Estimates of Complications of Medical Care in the Adult U.S. Population*, 1 *BMC HEALTH SERVS. RESEARCH* 2 (Mar. 29, 2001) (reaching the same conclusion but with better scientific analysis), at <http://www.biomedcentral.com/1472-683/1/2> (reaching the same conclusion but with better scientific analysis).

³ *QUALITY CHASM*, *supra* note 1, at 2.

⁴ See *id.* at 11 (stating that health care is now \$1.1 trillion or 13.5% of the GDP).

⁵ *Id.* at 3.

⁶ Thomas R. McLean, *The Implications of Patient Safety Research & Risk Managed Care*, 26 *S. ILL. U. L.J.* 227 (2002).

⁷ *Id.* at 39; see also JONAS & KOVNER’S HEALTH CARE DELIVERY IN THE UNITED STATES, 372-74 (Anthony R. Kovner & Steven Jonas eds., 6th ed. 1999) [hereinafter *HEALTH CARE DELIVERY*] (explaining relationship of cost containment to quality of health care).

⁸ *QUALITY CHASM*, *supra* note 1, at 191-93. There is no question that pecuniary incentives associated with fee-for-service medicine facilitate the over utilization of health care services, while the pecuniary incentives associated with managed care

Overuse refers to the provision of health services for which the potential risks outweigh the potential benefits. Underuse indicates that a health care service for which the potential benefits outweigh the potential risks was not provided. Misuse occurs when otherwise appropriate care is provided, but in a manner that does or could lead to avoidable complications.⁹

“As a result of overuse, underuse, and misuse of health care services, our society pays a substantial price.”¹⁰

Accordingly, the Institute of Medicine opines that “[i]f we want safer, high-quality care, we will need to have redesigned systems of care, including the use of information technology to support clinical and administrative processes.”¹¹ To narrow the quality chasm in health care, the Institute of Medicine recommends the adoption of six goals to improve our health care system: (1) make it safe (defined as the avoidance of injury), (2) make it effective (as determined by evidence based medicine), (3) make it patient-centered (that is the system is to be respectful and responsive to the needs of patients), (4) make it timely (free of delays), (5) make it efficient (free of waste), and (6) make it equitable (delivered in a non-discriminatory manor).¹² To achieve all of these goals, the Institute of Medicine is advocating that in the 21st century, a collaborative multidisciplinary team approach, rather than the traditional autonomous solo practitioner model, be employed in the delivery of health care.¹³

“Health care is not just another service industry.”¹⁴ Accordingly, the Institute of Medicine anticipates that collaborative

medicine facilitate the under utilization of health care services. See Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 52 FLA. L. REV. 1, 35 (2001) (explaining the effect of financial incentives a fee for service reimbursement system). But “misuse,” as Institute of Medicine defines it, is the occurrence of an adverse event (“avoidable complications that prevent patients from receiving full potential benefits of a service”) and is common to both systems of reimbursement. TO ERR IS HUMAN, *supra* note 2, at 16.

⁹ QUALITY CHASM, *supra* note 1, at 226.

¹⁰ *Id.* at 225.

¹¹ *Id.* at 4.

¹² *Id.* at 5-6.

¹³ See *id.* at 210-11. Collaborative multidisciplinary health care delivery contemplates the replacement of physicians with physician extender.

¹⁴ *Id.* at 207.

multidisciplinary health care delivery will change both the accountability and the standard by which health care providers are measured and therefore, the nature of the relationships between providers and patients.¹⁵ Consequently, implementation of a new health care system will require that the health care workforce, that employs about six million individuals, with a variety of educational backgrounds, will need to correspondingly change.¹⁶ Because of this diversity, implementation of a new health care system will not be a simple process.¹⁷ To facilitate the introduction of collaborative multidisciplinary health care delivery, the Institute of Medicine recommends that the work place be prepared by a three-prong approach: (1) modifying clinical education, (2) modifying the nature of professional regulations, and (3) modifying the existing liability coverage.¹⁸ While the methodology by which we modify clinical education is beyond the scope of this article, this article shall examine the potential for, and the consequences of, liberalizing the scope of practice for physician extenders.¹⁹ If the state professional board enabling acts are modified to allow for increasing the independence of physician extenders, to provide for the collaborative multidisciplinary practice of medicine, then it logically follows that we must move from a traditional tort system of liability for compensation of medical injury to an enterprise liability system for compensation of medical injury. This is necessary in order to provide physician extenders and their employers with the proper financial incentive to maintain the current quality of health care.²⁰

¹⁵ See *id.* at 211 (discussing how the changing relationship “calls for new skills in communication and support for patient self-management”).

¹⁶ *Id.* at 207.

¹⁷ *Id.*

¹⁸ *Id.* at 207-19.

¹⁹ In this article, physician extenders are contemplated broadly as any individual who provides a medical service in lieu of a physician. Thus physical, respiratory, and occupational therapist are physician extenders, as well as, physician assistants (PAs), advanced practice nurses (APNs), and certified registered nurse anesthetists (CRNAs). A physician, in turn, is a licensed practitioner of medicine or osteopathy. While chiropractors, licensed psychologists and pharmacists provide medical-type services, independent of medical community, chiropractors, licensed psychologists and pharmacists are neither physicians nor physician extenders for purpose of this article. However, a “clinical pharmacist” (someone holding a Pharm D degree) is a physician extender.

²⁰ In essence, an analogous argument arises in the discussion of the multidisciplinary practice of law; if we are going to allow lawyers to practice in collaborative

III. POLICE POWER AND STATE PROFESSIONAL BOARDS

A. Historical Perspective of Police Power

Since colonial times, medicine has been regulated at the state level.²¹ Early laws were primarily concerned with disease control and nuisance abatement.²² At the time of the Constitutional Convention, Philadelphia was decimated by an epidemic of Yellow fever.²³ Fear of communicable disease permeated society, resulting in the recognition that “the government, under the old doctrine of societal self-defense, had plenary power to impose restrictions on property and persons to prevent to [sic] spread of disease; and second, that this power belonged to the states.”²⁴

After the Civil War, the States began to shift their regulatory emphasis from public health to formal regulation of the medical profession.²⁵ While there was no shortage of self-proclaimed and unschooled physicians prior to the Civil War, absent the development of scientific knowledge, little distinguished the antebellum physician from his herbalist and charlatan colleagues. Consequently, “[i]n the minds of the populace and the legislatures, there was no justification for setting some physicians up with a state-enforced monopoly through licensing them, and excluding other physicians.”²⁶

However, by the 1880s a scientific basis had developed for the understanding of disease processes. Ignaz Semmelweis’ hand washing recommendations had become an established practice, as had Joseph Lister’s antiseptic techniques. Building

situations, then the non-lawyers needs to step up to the ethical standards of the legal profession. See Nathan Koppel, *What, Me Worry?*, Sept. 2, 2000, <http://www.law.com/cgi-bin/gx.cgi/AppLogic+FTContentServer?pagename=law/View&c=Article&cid=ZZZ12DISACC&live=true&cst=1&pc=0&pa=0> (discussing multidisciplinary practice of law).

²¹ Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 202 (1999).

²² *Id.* at 203.

²³ *Id.* at 205.

²⁴ *Id.* (citations omitted).

²⁵ Prior to 1890, “legislators were concerned with improving the quality of medical care, assuring fair pricing for medical services, and achieving other societal goals, such as effective control of communicable diseases.” *Id.* at 210.

²⁶ *Id.* at 207.

on the work of Pasture, Koch formulated his famous “postulates” for the identification of an infectious disease. With a firm understanding of infectious disease and Morton’s introduction of anesthesia, Billroth was able to perform the first gastric resection. Thus, by the mid-1880s, application of medical science distinguished the practice of medicine from other remnants of medieval mysticism. “Once medical science began to offer effective treatments, it was in the interest of the public for physicians to be educated in these treatments and the underlying medical science.”²⁷ For the first time, States began to prohibit the performance of ineffective and dangerous treatments. In addition to direct prohibitions of certain practices, States also initiated licensure and scope of practice acts to regulate the practice of medicine.²⁸ Unfortunately, States elected to avoid defining allowable medical practice in terms of specific procedures or methods of practice. Rather, pursuant to state regulation, the “practice of medicine [was] defined in terms of the diagnosis and treatment of illness in the manner used by physicians who [met] the training requirements for licensure. This effectively delegate[d] the definition of appropriate medical practice to medical schools, residency programs, and their private accreditation agencies.”²⁹

B. Professional Licensure

State licensure and scope of practice acts are predicated on the delegation of police power to the States.³⁰ The extent to which a State could regulate the practice of medicine was challenged in *Dent v. West Virginia*.³¹ At the time, West Virginia granted a medical license in one of three ways: (1) the candidate

²⁷ *Id.* at 210.

²⁸ The discussion here will focus on physicians. A parallel discussion on state licensure and scope of practice acts associated with physician extenders is omitted. *But see* Dolores Sheppard, *Physician Extenders in Managed Care: Reducing Risk Through Supervision and Credentialing*, 14 J. HEALTHCARE RISK MGMT. 12 (1994).

²⁹ Richards, *supra* note 21, at 211. Defining medicine in terms of “diagnosis and treatment” raises the fundamental question of what is the practice of medicine in the 21st Century when patients have become the primary care physicians.

³⁰ The Constitution limits the power of the federal government to those that are defined. Under the Constitution the authorization to act in the general welfare of the population was relegated to the States. Hence, the States rather than the federal government traditionally regulated public health and medicine under the rubric of “police powers.”

³¹ 129 U.S. 114 (1889).

was a graduate of a “reputable medical college” (2) the candidate had been in practice for ten years period to the enactment of the State’s licensing act, or 3) the candidate passed an examination by members of the state board of health.³² Failure to obtain licensure by one of these prescribed methods constituted the unauthorized practice of medicine. Dent, who had not been in practice for ten years, had only a diploma from the American Medical Eclectic College of Cincinnati, Ohio.³³ The Board of Health ruled that Dent’s diploma was not from a reputable medical school as intended by the statute. Dent was ultimately fined and enjoined from continuing to practice medicine.

Dent appealed to the Supreme Court arguing that the State had denied him his property right to practice his profession without due process of law and due compensation. The Court held that individuals have a right “to follow any lawful calling, business, or profession” but this right had to yield to state imposed conditions for the protection of society.³⁴

Because States are to provide for the general welfare, States are authorized to prescribe all “regulations as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity, as well as of deception and fraud.”³⁵ The balancing point against which the interest of the individual was leveraged against the interest of the State was to be set by a reasonable analysis of the facts of the case. Accordingly, a State was authorized under its police power to restrict an individual’s right to practice medicine, unless the restriction bore no relationship to the practice of medicine.³⁶ Accordingly, the Court upheld Dent’s conviction.³⁷

³² *Id.* at 115-17.

³³ *Id.* at 118.

³⁴ *Id.* at 121.

³⁵ Richards, *supra* note 21, at 217.

³⁶ *Dent*, 129 U.S. at 114.

³⁷ *Dent* and its progeny concern a State’s authority to limit an individual’s entry into the medical profession. If a State acts to limit a licensed practitioner by suspension, revocation, or non-renewal, greater scrutiny is placed on the State’s action. Under such situations, the State’s authority is limited by State’s administrative procedure act and constitutional limits placed on state actors. *Id.* at 218-19; *Cf. Physician Licenses May Be Revoked Without Appellate Court Hearing*, CAL. HEALTH L. MONITOR, Apr. 17, 2000, at 3 (observing that recent California legislative changes have moved to streamline the administrative process to remove incompetent physicians).

“Despite the enormous expansion of individual rights jurisprudence since the early constitutional period, the United States Supreme Court has not substantially limited the police power as it relates to public health disease control.”³⁸ Thus in *Kansas v. Hendricks*,³⁹ the Court would not release a sexual predator, convicted of multiple offenses, because the law upon which the individual was convicted was grounded in public health law.⁴⁰ Moreover, in *Pegram v. Herdrich*,⁴¹ the Supreme Court’s most recent foray into health care, the Court remains deferential to the states in the field of health care regulation. At issue in this case was the extent to which the comprehensive federal statute ERISA displaced traditional state laws. In holding that ERISA does not preempt a state medical malpractice action against an ERISA plan, the Court stated that health care was the “subject of traditional state regulation.”⁴²

C. Limitation of the Scope of Practice

Implicit in the State’s power to restrict the practice of medicine to licensees is the power to define the scope of practice of the licensee.⁴³ With regard to the validity of the physician’s scope of practice, the law has long been forged from cases concerning the State’s right to regulate narcotics and abortion.⁴⁴ The first Supreme Court opinion on this subject was *Minnesota ex rel. Whipple v. Martinson*, which concerned a State’s authority to prohibit a physician from dispensing narcotics to a patient directly.⁴⁵ Minnesota had passed a law that prohibited a physician from dispensing narcotics without creating an audit trail.⁴⁶ In upholding the State’s conviction of a physician for violation of the act, the Court took an expansive view of “public health and welfare.” According to the *Martinson* court, a State has such a right to exercise its police power “in the interest of the public health and welfare, that it is unnecessary to enter upon a discussion of it be-

³⁸ Richards, *supra* note 21, at 205-06.

³⁹ 521 U.S. 346 (1997).

⁴⁰ See Richards, *supra* note 21, at 205-06 (noting that *Hendricks* “explicitly relied on *Jacobson v. Massachusetts*, a 1905 smallpox immunization case.”) (citation omitted).

⁴¹ 530 U.S. 211 (2000).

⁴² *Id.* at 237.

⁴³ Richards, *supra* note 21, at 219.

⁴⁴ *Id.*

⁴⁵ 256 U.S. 41 (1921).

⁴⁶ See *id.* at 43-44.

yond saying that it is too firmly established to be successfully called in question."⁴⁷ *Martinson* has been reaffirmed by a more recent Supreme Court case.⁴⁸

*Whalen v. Roe*⁴⁹ provides another recent and detailed analysis of the validity of a state law governing the scope of practice.⁵⁰ In *Whalen*, both patients and physicians challenged New York's use of a public health law⁵¹ that required that Schedule II narcotics be prescribed on serially numbered triplicate prescription forms. These forms contained detailed information about the patient receiving the drug. One copy of the prescription form was sent to the state and the information was entered into a centralized computer bank. Patients and physicians alleged that the public health law was a violation of a patient's constitutional right to privacy.

The *Whalen* Court began its analysis by taking notice that the law in question arose after a special commission was established by the state legislature to evaluate the scope of practice regulations, which found that the prior laws controlling narcotics to be deficient. It also noted that other states (California and Illinois) had similar statutory schemes to the proposed regulatory scheme.⁵² The Court also reviewed the State's measures to ensure that a patient's records remained private. Accordingly, the Court opined that New York's law was "manifestly the product of an orderly and rational legislative decision."⁵³ States have a "vital interest in controlling the distribution of dangerous drugs."⁵⁴ Therefore, the law was "a reasonable exercise of New York's broad police powers."⁵⁵

But the Court also recognized that because dissemination of such personal information could result in a reluctance of doctors to prescribe, and patients to use, otherwise appropriate medications, there was merit in the appellee's assertion that the statute invades a constitutionally protected 'zone of privacy.'⁵⁶ No evi-

⁴⁷ *Id.* at 45.

⁴⁸ See *Robinson v. California*, 370 U.S. 660, 664 (1962).

⁴⁹ 429 U.S. 589 (1977).

⁵⁰ It is axiomatic that case law that upholds scope of practice laws for physicians also upholds scope of practice laws for physician extenders.

⁵¹ See *Whalen*, 429 U.S. at 591.

⁵² *Id.* at 592.

⁵³ *Id.* at 597.

⁵⁴ *Id.* at 598.

⁵⁵ *Id.*

⁵⁶ *Id.* at 598.

dence was admitted to suggest that the privacy safeguards within the statute would be administered improperly.⁵⁷ Even without public disclosure, the Court recognized the right of the State to receive private information to administrate public health; accordingly, collecting such information does not “automatically amount to an impermissible invasion of privacy.”⁵⁸ Thus, in upholding the state statute, the *Whalen* court placed the review of professional scope of practice statutes on a rational basis standard, subject only to the balancing of the individual’s privacy.

Balancing individual privacy against a State’s interest in regulating public health also arose in abortion and contraceptive cases. However, because the physicians are only bystanders in these cases, which created broad rights of privacy for patients, the abortion cases only created “very limited rights for physicians.”⁵⁹ In fact, “despite the substantive reality that [these cases involve the prosecution of a physician] for a crime,” in aggregate, these cases stand for the State’s authority to limit the scope of practice of a physician.⁶⁰

In *Griswold v. Connecticut*⁶¹ the Court held that a physician did have standing to challenge a state law that forbids the dissemination of contraceptive material. But, in the Court’s calculus, “physicians are involved because the state has restricted the provision of these particular medical services to physicians.”⁶² Thus *Griswold* implicitly recognizes that States have the right to regulate the scope of practice of physicians. Subsequent abortion cases have held that a State may regulate abortion to the same degree that it regulates any other surgical procedure.⁶³ Finally, *Roe v. Wade*⁶⁴ set

⁵⁷ *Id.* at 601.

⁵⁸ *Id.* at 602.

⁵⁹ Richards, *supra* note 21, at 221.

⁶⁰ *Id.*

⁶¹ 381 U.S. 479, 481 (1965).

⁶² Richards, *supra* note 21, at 221.

⁶³ See, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833, 878 (1992) (stating that “the State may enact regulations to further the health or safety of a woman seeking an abortion”); see also *Rust v. Sullivan*, 500 U.S. 173 (1991) (holding that the Department of Health and Human Services regulations, concerning abortion counseling as a method of family planning, are consistent with the First and Fifth Amendments). The abortion line of cases has been re-enforced by the courts position that States have the authority to regulate physician-assisted suicide. See *Washington v. Glucksberg*, 521 U.S. 702 (1997) (holding that prohibition against aiding a suicide does not violate the Due Process Clause); *Vacco v. Quill*, 521 U.S. 793 (1997) (holding that New York

the upper limit to which a State had authority to limit the scope of medical practice. *Roe* held that a State may not impermissibly interfere with a patient's privacy rights. Accordingly, a State cannot act through a physician to achieve a purpose it was forbidden to do directly. "Subject to this limitation, physicians have no constitutionally protected sphere of practice that is not subject to state regulation."⁶⁵

D. Circumvention of State Authority to Regulate Health Care Delivery

To provide safer but more cost-effective health care, *Crossing the Quality Chasm* recommends that health care delivery jettison the traditional approach, centered on autonomous physician providers, and move toward a collaborative multidisciplinary approach, centered on virtually independent functioning physician extenders as the primary providers.⁶⁶ To achieve this goal, the Institute of Medicine observes that the existing regulatory system stands as an obstacle because licensure and scope of practice laws "define how the health care workforce is deployed."⁶⁷ Such laws have provided physicians with a monopoly as independent health care providers. The heterogeneous nature of state licensure and scope of practice laws means that there is a great deal of variation among the several states in the quality of medical care that is rendered within its borders.⁶⁸ Nor do these state laws provide any assurance that health care providers maintain their clinical competency after licensure.⁶⁹ Moreover, the state licensure and scope of practice laws inhibit the use of telemedicine⁷⁰ and the formation of large multistate provider

statutes outlawing assisted suicide do not infringe fundamental rights nor involve suspect classifications).

⁶⁴ 410 U.S. 113 (1973).

⁶⁵ Richards, *supra* note 21, at 222.

⁶⁶ See *QUALITY CHASM*, *supra* note 1, at 208-10.

⁶⁷ *Id.* at 215.

⁶⁸ *Id.* at 216.

⁶⁹ *Id.* at 217.

⁷⁰ Nicolas P. Terry, *Cyber-Malpractice: Legal Exposure for Cybermedicine*, 25 AM. J.L. & MED. 327, 327-28 n.7 (1999). Telemedicine "typically refers to technologies, primarily preconvergence telephony, satellite and video, used to patch geographical holes in health coverage" that facilitate communication between a physician and patient. *Id.* at 327. While a general discussion of telemedicine is beyond the scope of this communication, notice is taken that the complexity of telemedicine itself provides a strong argument for the implementation of enterprise liability.

groups, both of which the Institute of Medicine believes are necessary for cost-effective health care.⁷¹

Thus, it is not a surprise that *Crossing the Quality Chasm* calls for the unification of state health care provider licensure and scope of practice law in order to provide for a predictable cost-efficient quality medical care.⁷² One approach to this problem would be to have a nationally uniform scope of practice act.⁷³ Alternatively, the country could move toward a mutual recognition model of state physician-extender licensure, in a manner analogous to how the country treats driver's license requirements.⁷⁴ Regardless of how the state provider licensure and practice acts are modified, the Institute of Medicine believes that they should be modified with an eye towards uniformity, facilitating technologic (computer) innovation and assuring that health care providers possess a minimum level of competence throughout their professional careers. However, for its part, the Institute of Medicine stated that it would be premature for it to comment on a specific approach to modernizing state health care regulation.⁷⁵

Uniformity of laws, whether the laws concern the sale of goods or securities, facilitate transactions, thereby reducing costs and providing a stable frame of reference for evaluating a transaction. There is no reason to believe that medical transactions behave differently. Hence, there is no question that uniformity of the laws governing the licensure of physicians and physician providers, that liberalize the scope of practice of physician providers, would go a long way towards providing more cost effective health care. But the preliminary question that *Crossing the Quality Chasm* sidesteps, with its comment that it would be premature of the Institute of Medicine to comment on

⁷¹ QUALITY CHASM, *supra* note 1, at 207-20.

⁷² *Id.* at 215.

⁷³ See *id.* (citing THE PEW PROF'L COMM'N, CONTEMPORARY ISSUES IN HEALTH PROFESSIONAL EDUCATION AND WORKFORCE REFORM (1993)); see also FED'N OF STATE MED. BOARDS, MAINTAINING STATE-BASED MEDICAL LICENSURE AND DISCIPLINE: A BLUEPRINT FOR UNIFORM AND EFFECTIVE REGULATION OF THE MEDICAL PROFESSION (1998) (discussing recommendations for uniform standards for the effective regulation of the medical profession), at <http://www.fsmb.org/uniform.htm> (last visited Feb. 5, 2002).

⁷⁴ See TO ERR IS HUMAN, *supra* note 2, at 142.

⁷⁵ QUALITY CHASM, *supra* note 1, at 202.

a specific unification process,⁷⁶ is just how is this uniformity to be achieved?

The review of state licensure and the scope of practice acts demonstrates that the place of health care delivery regulation is firmly in the hands of the state governments. The States set the quality of medical care providers within their boundaries according to their fiscal resources and the needs of their populace. States adjust the quality of medical care available in turn by adjusting the state licensing and scope of practice laws. Under the present system, if a State believed that quality of medical care was sub-optimal, due to a lack of physician extenders, the State could liberalize their licensing laws to attract physician extenders. Conversely, if a State perceived that it had an abundance of physician providers, it could heighten the requirements to obtain or maintain a medical license. Given the plurality of financial wherewithal of the States and the diversity of the patient population throughout the country, it is difficult to believe that the States will simply agree to unify their licensure and scope of practice acts.

Given that the States regulate medicine under authority of their police power, the federal government is limited in how it can implement the Institute of Medicine's recommendations to unify the medical licensure and provider scope of practice acts. Clearly, the federal government lacks the authority to unify medical licensure and scope of practice acts by fiat.⁷⁷ Rather, the federal government could unify the state medical licensure and scope of practice acts to facilitate health care delivery using

⁷⁶ *Id.*

⁷⁷ See *Alden v. Maine*, 527 U.S. 706, 749 (1999) (stating that the power to use a State's own legal apparatus against itself is the power "to commandeer the entire political machinery of the State against its will and at the behest of individuals"); *New York v. United States*, 505 U.S. 144, 188 (1992) (holding that the federal government cannot compel States to enact or administer federal regulatory programs, such that the State would have to provide for the disposal of radioactive waste within its borders). The federal government's usurpation of a State's traditional authority to regulate medicine and public health has already been attempted. The Health Security Act, H.R. 3600, 103d Cong., § 1161 (1993), was without question, intended to expand the scope of practice of physician extender by preempting state licensure and scope of practice acts: "No State may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals."

the more cost efficient physician extenders,⁷⁸ via two potential mechanisms: under the authority of the Commerce Clause, or by conditional payments for medical services.

Congress has the power to regulate interstate commerce.⁷⁹ Potentially, as telemedicine becomes big business,⁸⁰ the federal government could deem the practice of medicine to be commerce. Such a frontal assault on state licensure laws could be justified because such laws act as a trade barrier.⁸¹ Congress has used the Commerce Clause to remove state safety regulations that hindered the nation's commerce in the past.⁸² However, such an assault on the politically sensitive subject of the regulation of medicine appears unlikely.

Rather, the federal government would more likely unify the state medical licensure and the scope of practice regulations based on financial incentives.⁸³ Presently the federal government pays directly, or indirectly, a large part of all health care costs.⁸⁴ Thus, the federal government is in a strong negotiating position to leverage the adoption of uniform health care regulations. The government has already taken steps to provide quality and cost effective medical care for Medicare patients by promulgating the Hospital Conditions of Participation in Medi-

⁷⁸ See Chris L. Gore, *A Physician's Liability for Mistakes of a Physician Assistant*, 21 J. LEGAL MED. 125, 127-28 (2000) (discussing the various arguments that justify expanding physician extenders' roles).

⁷⁹ U.S. CONST. art. I § 8, cl. 3.

⁸⁰ It is probably only a matter of time before a Fortune 500 company like Time-Warner or Sprint enters the telemedicine market to capture market share for Roadrunner or ION, the high speed communication conduit products of the two companies respectively.

⁸¹ Cf. Susan E. Volkert, *Telemedicine: RX for the Future of Health Care*, 6 MICH. TELLECOMM. & TECH. L. REV. 147, 169 (2000) (noting that "many states' physician licensing boards have placed even more restrictions on consultations, making routine telemedical consultations impractical if not impossible").

⁸² See *Kassel v. Consol. Freightway Corp. of Del.*, 450 U.S. 622, 671 (1981) (ruling that a state truck safety regulation was overly burdensome on interstate commerce).

⁸³ See *South Dakota v. Dole*, 483 U.S. 203, 205-06 (1987) (stating that the federal government may condition distribution of federal highway funds on a state's adoption of a minimum age for the purchase of liquor); see generally Matt Stearns, *Lower Limit for Alcohol Becomes Law*, KANSAS CITY STAR, June 12, 2001, at A1 (discussing the amount of leverage the federal government has considering the State of Missouri's recently capitulation to a similar law).

⁸⁴ See HEALTH CARE DELIVERY, *supra* note 7, at 373-74 (explaining how the federal government became a major source of health care funding beginning in the 1960s).

care Part A.⁸⁵ Under the condition of participation regulations, if a hospital wishes to be reimbursed, the hospital will be required to meet certain conditions set out by Health Care Financing Administration (HCFA)⁸⁶ to be a provider institution, regardless of independent accreditation status. HCFA has proposed that patients have the right to receive health care in "a safe setting."⁸⁷ Accordingly, pursuant to the proposed regulations, hospitals are to monitor the delivery of health care providers of all types. In essence, what HCFA is mandating, under conditions of participation, is that hospitals police their health care providers. HCFA has privately suggested that a hospital's failure to monitor and implement safety as a condition of participation will result in the loss of that institution's provider status.⁸⁸ The threat of the loss of provider status, in turn, will be a major incentive for hospitals to report unsafe physicians.⁸⁹ Similarly, to encourage cost effective health care, the federal government has taken steps to encourage the use of physician extenders. A physician may under certain circumstances, "bill Medicare for services rendered by certain types of physician extenders."⁹⁰ But to get this increased remuneration, HCFA re-

⁸⁵ Medicare and Medicaid Programs; Hospital Conditions of Participation; Provider Agreements and Supplier Approval, 62 Fed. Reg. 66,726 (Dec. 19, 1997) (to be codified at 42 C.F.R. pt. 416, 482, 485 & 489).

⁸⁶ The agency was recently renamed Center for Medicare and Medicaid Services. For purposes of uniformity, this article will use the old name.

⁸⁷ Medicare and Medicaid Programs; Religious Nonmedical Health Care Institutions and Advance Directives, 64 Fed. Reg. 67,028, 67,032 (Nov. 30, 1999) (to be codified at 42 C.F.R. pts. 403, 412, 431, 440, 442, 446, 456, 488 & 489). Interestingly, this rule was announced in tandem with the Institution of Medicine's report on medical errors.

⁸⁸ Letter from Pete Enko, Esq., Seigfried, Bingham, Levy, Selzer, & Gee, Kansas City, Mo., to Thomas McLean (Apr. 2001) (on file with author).

⁸⁹ More than ever, a hospital cannot afford to lose the revenue stream that is associated with being a Medicare provider. *See, e.g.*, Bruce Japsen, *Financial Hemorrhage: Hospitals Serving the Poor Are Bleeding Red Ink as the Uninsured's Ranks Grow, Health-Care Costs Climb and More Government Cutbacks Loom*, CHI. TRIB., Apr. 8, 2001, at C1 ("Hospital revenue was squeezed through much of the 1990s as managed care expanded. The Balanced Budget Act of 1997 reduced federal outlays. Now, the Bush administration is proposing to cut all but \$20 million of a \$140 million program linking the uninsured to hospitals and other providers.")

⁹⁰ Paul R. DeMuro & John D. Whipple, *Government's Current Compliance Initiatives - 1999*, in HEALTH CARE FRAUD & ABUSE: HOW TO NAVIGATE THE COMPLIANCE PROCESS 13 (1999) (citing Medicare Carriers Manual § 2050, which states that the medical service "(i) provided by the physician extender must be an integral part of a physician's diagnosis or treatment; (ii) provided must be under the 'direct supervision' of a physician (i.e., the physician must be present in the office suite and

quires a “physician supervision requirement for anesthetists in Medicare cases.”⁹¹

In short, while *Crossing the Quality Chasm* has opined that the most significant barrier to unitizing cost effective physician extenders is the patchwork of state licensure and scope of practice acts, unification of these laws is not insurmountable. Rather, the federal government, as the largest purchaser of health care service, is in a position to facilitate the liberalization of physician extender’s scope of practice through its reimbursement policies. However, because of the disparate educational levels between physicians and physician extenders, if physician extenders are to increase their scope of practice independent of physicians, then it becomes appropriate to reconsider the legal standards by which the medical care as provided by physician extenders is judged.

E. The Potential Opposition by Organized Medicine

Before contemplating the legal standards for physician extenders, comment is appropriate concerning what opposition the Institute of Medicine and the federal government might encounter from organized medicine. Clearly, liberalizing the scope of practice acts for physician extenders will erode the monopolistic hold that physician have on health care delivery; consequently a shift to physician extenders realistically translates to less need for physicians. As physician are displaced from the workplace and physician income falls, the American Medical Association (AMA) will certainly have *something to say* concerning the shift to a physician extender-based health care system.

Unfortunately for physicians, the AMA will likely have *little say* because the AMA is largely unprepared and/or may be precluded from vigorously challenging a move to a physician extender based health care delivery system. The AMA has contradictory policies when it comes to willingness to be subservi-

immediately available to provide assistance and direction throughout the time the physician extender is performing the services); (iii) must be performed by an employee of the supervising physician or such physician’s affiliated medical group (i.e., the physician extender must be employed by the supervising physician or his medical group, or leased by such person or entity); and (iv) must be something ordinarily done in a physician’s office or clinic”).

⁹¹ Elliott B. Oppenheim, *MedBytes*, MED. MALPRACTICE L. & STRATEGY, Aug., 2000, at 9.

ent to the government.⁹² A search of the AMA's constitution, ethical rules, and policies failed to reveal any statements concerning physician extenders except to oppose the right of the physician extenders to receive direct reimbursement.⁹³ In addition, the AMA through its subsidiary the National Patient Safety Foundation,⁹⁴ has already signaled its support of the direction that the Institute of Medicine is taking in a press release on the Internet, issued just two weeks after *To Err is Human* was published. Moreover, many of the AMA's positions on health care have been self-serving⁹⁵ or actually play into the hands of the proponents of physician extenders.⁹⁶ Thus it is unlikely that any

⁹² The American Medical Association's policies can be viewed online at http://www.ama-assn.org/apps/pf_online/pf_online. Compare AM. MED. ASS'N, H-205.997, AMA STATEMENT ON VOLUNTARY HEALTH PLANNING (2001) (stating "[t]he protection of the public welfare is properly a concern of government and activities to protect the public may be implemented in a variety of ways. However, local voluntary health planning is a creative process and, therefore, should not include the use of regulatory sanctions"), with AM. MED. ASS'N, H-160.998, HEALTH CARE (2001) (stating that "[t]he AMA believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest; and that it will not be a willing party to implement any system which we believe to be detrimental to the public welfare").

⁹³ AM. MED. ASS'N, H-35.993, OPPOSITION TO DIRECT MEDICARE PAYMENTS FOR PHYSICIAN EXTENDERS (2001), available at http://www.ama-assn.org/apps/pf_online/pf_online (stating that "[o]ur AMA reaffirms its opposition to any legislation or program which would provide for Medicare payments directly to physician extenders, or payment for physician extender services not provided under the supervision and direction of a physician").

⁹⁴ The National Patient Safety Foundation, a nonprofit organization, was formed in 1997 as a collaborative effort between the American Medical Association, CNA HealthPro, and 3M. The National Patient Foundation is in the AMA's Chicago headquarters. For more information see the organization's web site at <http://www.npsf.org>.

⁹⁵ In recent years the AMA has amended its ethical cannons to allow physicians to unionize. Sarah A. Klein, *The Third Time Is the Charm for a Call by the AMA House of Delegates that the Association Form a National Labor Organization Representing Physicians*, AMNEWS, July 5, 1999, available at http://www.ama-assn.org/sci-pubs/amnews/pick_99/prl10705.htm#top. It also allows physicians to run a retail sales operation from their office. See Diane M. Gianelli, *Ethics Council Revisits Office-Based Product Sales: CEJA's Latest Take on the Sale of Health-Related Products from Physician Offices Includes New Due Diligence and Disclosure Responsibilities*, AM. MED. NEWS, June 7, 1999, at http://www.ama-assn.org/sci-pubs/amnews/pick_99/anna0607.htm. While the AMA can justify both of these modifications under the pretext of patient benefit, the subtext unmistakably denotes subordination of patient interest to preserve physician's income.

⁹⁶ One example is the fact that doctors want to work only a limited number of hours per week, which provides a strong argument for use of physician extenders. See

opposition by the AMA to the changing landscape of health care providers will be effective.

IV. LEGAL STANDARDS FOR PHYSICIAN EXTENDERS

The rationale behind increasing utilization of physician extenders is that physician extenders “lower cost of providing health care, reduce[] physician stress, higher levels of patient satisfaction, and improve[] quality of care resulting from the team approach.”⁹⁷ Physician extenders exist to enable physicians “to delegate certain health tasks to physician assistants where such delegation is consistent with the health and welfare of the patient and is conducted at the direction of and under the responsible supervision of the physician.”⁹⁸ This suggests that at the very least, society views physician extenders as subordinate to physicians.

A. Differentiating Physicians and Physician Extenders

To be a physician, one must obtain a doctorate level of training. Physicians must not only attend four years of college but must also attend an accredited medical school for four years of additional postgraduate education. To receive a license to practice medicine, a physician must work under supervision for an additional year as an intern and then pass a licensing examination.

In the present marketplace, if a physician is to have any hope of reasonable remuneration, the physician needs to achieve the status of “board certification.” To become board certified, a physician has to attend an accredited residence program for an additional two to six years (depending on the specialty) of training to become board eligible. A board certification examination

Jay Greene, *Petition Asks OSHA to Limit Resident Work Hours*, AM. MED. NEWS, May 21, 2001, at <http://www.ama-assn.org/sci-pubs/amnews/pick-01/prsa0521.htm>. This is because, as the physicians must recognize, disease-processes operate twenty-four hours per day. Thus, if the doctors want time off, the Institute of Medicine would argue that liberalization of physician extender’s scope of practice would provide a cost effective solution to this physician’s request.

⁹⁷ Patrick Knott & Kathleen Ruroede, *One Solution for Managing Risks During Cutbacks in Residency Training Programs*, 11 RISK: HEALTH, SAFETY & ENV’T 35, 39 (2000) While evidence exists to the contrary for each of these arguments, for the purposes of this article, all are assumed to be true.

⁹⁸ Gore, *supra* note 78, at 125 (citing Illinois Physician Assistant Act of 1987, 225 ILL. COMP. STAT. ANN. 95/1 (West 1998)).

is given to board eligible candidates anywhere from six months to two years after the completion of residency. In some specialties (e.g., general surgery), the applicant for board certification must pass not only a written qualifying examination but also an oral certification examination.⁹⁹ In short, to become board certified in any field, a physician must obtain at least seven years of training after completing college.

Board certification has been likened “to state licensure: At one point in time, an individual has passed a general examination testing minimum competence; generally, no retesting is required to ascertain continuing competence or skill in newly developed procedures.”¹⁰⁰ While “board certification should not be the sole criteria for assuring patient safety,”¹⁰¹ it is a standard of achievement that is recognized nationally.¹⁰² However, since the mid-1980s, board certification in many fields including internal medicine and general surgery was granted conditionally on the physician engaging in lifelong contiguous medical education (CME).¹⁰³ To maintain their status as being “board certified,” physicians must demonstrate that their education remains up to date by going through recertification every ten years. Recently, the American Board of Internal Medicine (ABIM) has decided that this is not enough. The “publics’ growing demand for physician accountability”¹⁰⁴ coupled with the quickened pace of

⁹⁹ Caution should be exercised when evaluating the “title ‘board certified’ because it can lead to a false sense of security regarding competence.” Medical Board of California, CAL. REG. L. REP., Summer 1999, at 23, 30. I concur. In this article board certified implies only certification by one of the members of the American Board of Medical Examiners. For a discussion of other attempts to provide a title independent of substance, see Thomas R. Russell, *From My Perspective*, 86 BULL. AM. C. OF SURGEONS 3 (2001) (discussing a proposed pseudo-board certification in “dermatology surgery”). The American College of Surgeons opposes this proposal. *Id.*

¹⁰⁰ Medical Board of California, *supra* note 99, at 30.

¹⁰¹ *Id.* at 31.

¹⁰² See Brian P. Fitzgerald, *Can the Pattern Jury Instruction on Medical Malpractice Be Revised to Reflect the Law More Accurately?*, 71 N.Y. ST. B.J., Nov. 1999, at 32, 34 (stating that board certification “implies a greater degree of knowledge, skill and ability, regardless of locality”).

¹⁰³ Continuing medical education is completely analogous to continuing legal education, with the exception that physicians are generally required more hours than their attorney counterparts.

¹⁰⁴ Rebecca A. Clay, *ABIM Revises Recertification Requirements to Promote Continuous Professional Development*, 30 CARDIOLOGY 1, 1 (2001) *see also* Wallace P. Ritchie, Jr., *The Measurement of Competence: Current Plans and Future Initiatives of the American Board of Surgery*, 86 BULL. AM. C. OF SURGEONS 10, 11 (2001)

medical advances necessitates the institution of "continuous professional development."¹⁰⁵ By 2004, the ABIM plans to institute a ten-year cycle of professional education involving self-testing, patient and peer group feedback, and formal recertification and credentialing.¹⁰⁶

In contrast to the arduous formal training of a physician, which exceeds the formal training of all other professions, to be a physician extender, all that one must achieve is a masters degree level of training. Certified registered nurse anesthetists (CRNAs) "complete a four-year baccalaureate program in nursing, then a nursing license, followed by a minimum twenty-four months of additional training in the delivery of anesthesia."¹⁰⁷ CRNAs must also "pass a rigid certification exam in anesthesia."¹⁰⁸ Physician assistants "receive their training in accredited programs that matriculate anywhere from twelve months to forty-two months, depending on the state."¹⁰⁹ Advance Practice Nurses (APNs)¹¹⁰ must "have advanced training of nine months to two years beyond the registered nurse (RN) degree. To have "independent prescribing authority, approximately thirty 'contact hours' in pharmacological management, ten of which must be in 'pure pharmacology,' are mandated."¹¹¹ Midwifery is also a graduate level specialty.¹¹²

Physician extenders, unlike physicians, have no formal postgraduate training. Physician extenders do not have to complete an internship or residency program. While there is some state-to-state variability, a physician extender generally only

(indicating that the same process is to be initiated to maintain board certification in general surgery).

¹⁰⁵ Clay, *supra* note 104, at 1; Ritchie, *supra* note 104, at 11.

¹⁰⁶ Clay, *supra* note 104, at 1, 27.

¹⁰⁷ Jerry Cromwell, *Barriers to Achieving a Cost-Effective Workforce Mix: Lessons from Anesthesiology*, 24 J. HEALTH POL., POL'Y & L. 1331, 1332 (1999).

¹⁰⁸ *Id.* at 1354.

¹⁰⁹ Joseph Mark Saponaro, Note, *Determining the Immunity "Measuring Stick": The Impact of the Health Care Quality Improvement Act and Antitrust Laws on Immunity Aspects of Granting Privileges to Physician Assistants*, 47 CLEVE. ST. L. REV. 115, 122 (1999).

¹¹⁰ In some locations APNs are referred to by the appellation of "nurse clinician."

¹¹¹ James L.J. Nuzzo, *Independent Prescribing Authority of Advanced Practice Nurses: A Threat to the Public Health?*, 53 FOOD & DRUG L.J. 35, 43 (1998).

¹¹² See generally *Sweeney v. Athens Reg'l Med. Ctr.*, 709 F. Supp. 1563 (M.D. Ga. 1989) (noting that plaintiff held a degree in nurse-midwifery from a graduate school).

needs to graduate from an accredited nursing program and achieve a passing score on the licensing exam to begin practice.¹¹³ However, some States require that their physician extenders, like their physicians, be of "good moral character."¹¹⁴ Importantly, beyond licensure, there is no objective measure to assess the competency of a physician extender.¹¹⁵

Despite both a significant difference in education and documented evidence of competency, some commentators have asserted that physician extenders receive sufficient training to permit "competent diagnosis and treatment of patients at a level equal to a licensed physician."¹¹⁶ Advocates of physician extenders assert that "no study" has ever shown any significant difference in the quality of anesthesia care provided by nurse anesthetists and anesthesiologists.¹¹⁷ Like all groups of professionals, some physicians are excellent and some are marginal. Similarly, some physician extenders are excellent and have greater clinical acumen than the physician supervising them, while some physician extenders are marginal. Thus, there is no question that there is considerable overlap between physicians and physician extenders with regard to individual intelligence, diligence and humanity. Because of this wide intergroup variability in quality, it is not surprising that a statistically significant difference between physicians and physician extenders has not been demonstrated.¹¹⁸

However, to conclude that the care rendered by the average physician is the same as the care rendered by the average physician extender is, at best, naive. There is no a priori reason to believe that a health care provider vested with a postdoctoral level of education (a physician with board certification) produces the same quality of work product as a health care provider vested with only a masters degree level of education (a physician extender). In fact, to hold to the contrary (that physician extenders provide the same quality of care as physicians) is il-

¹¹³ Gore, *supra* note 78, at 127.

¹¹⁴ *Id.*

¹¹⁵ See Michael H. Cohen, *The Risk of Malpractice Liability in Credentialing Complementary and Alternative Medical Providers*, 42 ORANGE COUNTY LAWYER, Apr. 2000, at 16, 17 (referring to chiropractic board certification).

¹¹⁶ Gore, *supra* note 78, at 127-28.

¹¹⁷ Oppenheim, *supra* note 91, at 9 (quoting Jan Steward, president of the American Association of Nurse Anesthetists).

¹¹⁸ See generally STANTON A. GLANTZ, PRIMER OF BIOSTATISTICS (1981) (examining how to test for differences between groups).

logical for two reasons. If it were true, society would no longer have any incentive to provide health care education beyond the masters degree level; and second, there would be no incentive for individuals to invest in the additional years required to become a physician. Moreover, to conclude the quality of the work product of a physician extender is the same as a physician's work product would be analogous to asserting that the quality of the work product of a paralegal is same as an attorney's work product.¹¹⁹

B. A Differential Legal Standard for Physicians and Physician Extenders

Despite the self-serving rhetoric of the physician extender community, a profound difference in the quality of care exists between patients treated by a physician and patients treated by a physician extender.¹²⁰ Accordingly, physicians and physician extenders are held to different standards of care.¹²¹ Thus, a dif-

¹¹⁹ In addition to the intuitive nature that the work product of a physician extender would not be equivalent to that of a physician work product, there are several other lines of evidence that suggest that this assertion is true. Despite the U.S. Military's extensive experience employing physician extenders, "significant" quality of care issues remain. Discussion with Col. Charles Van Way, M.D. (Mar. 2001). This is in part because the physician extenders do well with if a healthy patient has only one problem like a broken leg, but the quality of care deteriorates as the patient becomes sicker and the medical problems become more complex. Similarly, while it appears that fifty percent of all medical errors are preventable is a consistent finding, a recent publication from England has documented that the majority of preventable errors occur not in the operating room. Instead, "ward-based procedures were due to poor technique and poor monitoring of unsupervised junior staff." Graham Neale et al., *Exploring the Causes of Adverse Events in HNS Hospital Practice*, 94 J. ROY. SOC'Y MED. 322, 325 (2001). This suggests that the majority of preventable errors are not made by the well-trained physician but rather the less well-trained health care providers. Finally, the mere fact that physician extenders are granted by the law a different standard of care than their physician counterparts is a tacit acknowledgement by the legal community that the quality of care of the physician extender is lower than that of the quality of care provided by the physician provider.

¹²⁰ See Richards, *supra* note 21, at 235.

For example, there is no "corporate practice of nursing" doctrine because the courts have always assumed that nurses will be under the direction of physicians, and that physicians are subject to corporate practice bans. Another example is the learned intermediary doctrine for prescription drugs.

The courts do not accept that NPPs are learned intermediaries.

Id. (citations omitted).

¹²¹ See Gore, *supra* note 78, at 130 (discussing different standards of care for physician assistants); Phyllis Coleman & Ronald A. Shellow, *Extending Physician's*

ferent 'measuring stick' needs to be used to evaluate physician and physician extenders.¹²² The deferential treatment provided by the courts is perhaps the best evidence that the quality of care rendered by physician extenders is below that of physicians. If physician extenders provided the same quality of care, there would be no reason to provide the physician extenders with different treatment.

Physicians must render to patients a standard of care that another reasonably prudent physician would provide under the same or similar circumstances.¹²³ This standard is modified based on the nature of the physician's practice and the location of the physician's practice. If the physician is a specialist, then that physician will owe his or her patient a greater degree of care.¹²⁴ A cardiologist must exercise greater clinical acumen when treating a patient with angina than a family practitioner. Conversely, if the physician practices in a rural area, practically speaking, the degree of care owed to a patient is not as onerous because rural areas usually are not required to possess the newest machinery and equipment.¹²⁵

Because physician extenders must render patients a standard of care that another reasonably prudent physician extender would provide under the same or similar circumstances,¹²⁶ in a medical malpractice action (just like a physician), the plaintiff must demonstrate that the physician extender breached the stan-

Standard of Care to Non-Physician Prescribers: The Rx for Protecting Patients, 35 IDAHO L. REV. 37, 72 (1998) (same).

¹²² Saponaro, *supra* note 109, at 136 (referring to competition for work place position between MDs and non-MD providers).

¹²³ See *Boyce v. United States*, 942 F. Supp. 1220-25 (E.D. Mo. 1996); *Alef v. Alta Bates Hosp.*, 6 Cal. Rptr. 2d 900, 904 (Ca. Ct. App. 1992).

¹²⁴ See, e.g., *Johnson v. Westfield Mem'l Hosp.*, 710 N.Y.S.2d 862, 863 (Sup. Ct. 2000) (holding that as a specialist, an ophthalmologist is to be held to a higher standard of care than an average physician).

¹²⁵ The move away from the locality rule, which held physicians to different standard of care regarding *skill* has been described as follows:

[J]urisdictions abandoned the locality rule in favor of a national standard of care theoretically applicable anywhere in the country. The Supreme Court of Missouri abandoned the locality rule in favor of the national standard in the 1972 case of *Gridley v. Johnson*. The practical effect of this change in the law was to allow for the use of medical experts from other jurisdictions. This change in the law clearly had the result of blunting the effect of "the so-called 'conspiracy of silence'" among physicians.

Glenn E. Bradford, *The "Respectable Minority" Doctrine in Missouri Medical Negligence Law*, J. MO. B., Nov.-Dec. 2000, at 326, 326-27.

¹²⁶ See *Boyce*, 942 F. Supp. at 1225; *Alef*, 6 Cal. Rptr. 2d at 904.

dard of care owed to the patient.¹²⁷ Although Coleman and Shellow assert that physician extenders "can be held to the physician standard of care when performing tasks traditionally reserved to medical doctors,"¹²⁸ the rule for physician extenders remains that they must only provide a level of care that another reasonably prudent physician extender would provide under same or similar conditions.¹²⁹ Thus physician extenders provide a lower standard of care when compared with physician-providers.¹³⁰

Also, modification of general rule for physician extender's standard of care occurs under a different set of conditions than that for physicians. First, there is no rule of heightened care for a specialist. Provided that a physician extender is acting within their prescribed scope of duty, specialization does not exist. Thus, for example, a CRNA cannot specialize in cardiac anesthesia. If a CRNA provides anesthesia to a cardiac patient, the standard of care owed to the patient is only that care of another reasonable CRNA provider under the same or similar circumstance (providing cardiac anesthesia). Second, while the locality modification to a physician's standard of care has largely been abandoned, courts remain divided as to whether this standard of care for a physician extender is local or national in nature.¹³¹ In part, the perpetuation of the locality rule for physician extenders

¹²⁷ See *Bradford v. Alexander*, 886 S.W.2d 394, 396 (Tex. App. 1994) (providing elements of a medical malpractice action).

¹²⁸ *Coleman & Shellow*, *supra* note 121, at 73. While the authors cite cases that could be construed as setting the standard of care for physician extenders at the same level as physicians, these cases are *sui generi* in nature. See *Fein v. Permanente Med. Group*, 695 P.2d 665, 674 (Cal. 1985) (en banc) (holding a physician extender, in this case a nurse practitioner, to a physician's standard of care was a harmless error because the jury could not have reasonably found the nurse practitioner negligent under the physician standard of care without also finding the supervising physician similarly negligent); see also *Cent. Anesthesia Assocs. v. Worthy*, 333 S.E.2d 829, -34 (Ga. 1985) (upholding grant of summary judgment against CRNA for negligence per se, where CRNA improperly administered anesthesia without authorization or supervision, contrary to state statute).

¹²⁹ See *Paris v. Kreitz*, 331 S.E.2d 234, 247 (N.C. Ct. App. 1985); PROSSER AND KEETON ON THE LAW OF TORTS (W. Page Keeton et al. eds.) § 32 (5th ed. 1984) (stating "the cumulative effect of all of these rules has meant that the standard of conduct becomes one of 'good medical practice,' which is to say, what is customary and usual in the profession").

¹³⁰ See *MacDonald v. United States*, 853 F. Supp. 1430, 1438 (M.D. Ga. 1994) (finding that the minimal training required to become a physician's assistant does not operate as an adequate substitute for the training level of a doctor).

¹³¹ See *Gore*, *supra* note 78, at 131-32 (discussing various courts' approaches to the local versus national standard of care argument and concluding it is the "same or similar locality" standard).

reflects the heterogeneous conditions under which a physician extender is employed.¹³²

C. Liability Associated with Administration of Physician Extenders

While variability exists in the degree to which States grant autonomy to physician extenders, a medical director of some form¹³³ must still provide direction to physician extenders.¹³⁴ Accordingly, the medical director of a physician extender accrues liability either directly for negligent selection and retention of an incompetent physician extender, or vicariously under the doctrines of respondeat superior or the principle of ostensible agency.

1. Direct Liability: Negligent Selection and Retention of a Physician Extender

There are only two requirements to become a physician extender: 1) attainment of a masters level of formal education and 2) passing a state licensing examination. Little, therefore, distinguishes one physician extender from another, except perhaps letters of recommendation.¹³⁵ Moreover, because there is not a National Practitioner Data Bank for physician extenders, as there is for physicians, other than the state-licensing bureau, at present there is no governmental organization that profiles a

¹³² While physician extenders must be supervised, the degree of supervision is highly variable depending on personality of the supervising physician. Use of clinical guidelines and geographic location of the physician extender's practice also influence the level of care provided by physician extenders.

¹³³ In this capacity, the term "medical director" is used broadly. A medical director may be a solo practitioner who employs a single extender. At the other end of the spectrum, a medical director may supervise multiple physician extenders in non-traditional settings. See *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) (describing how medical directors supervise nurse physician extenders during utilization review decision making); *Murphy v. Bd. of Med. Exam'rs*, 949 P.2d 530, 536 (Ariz. Ct. App. 1997) (illustrating the fact that a medical directors decision to deny care is a medical decision); *State Bd. of Registration for the Healing Arts v. Fallon*, 41 S.W.3d 474, 477 (Mo. 2001) (same).

¹³⁴ See Patricia C. Kuszler, *Telemedicine and Integrated Health Care Delivery: Compounding Malpractice Liability*, 25 AM. J.L. & MED. 297, 324 (1999) (nothing that with respect to the patient, the doctor can function both as a provider and "as the supervisor of the physician extender").

¹³⁵ Even if the physician extender had a long employment history, checking with prior employers is unlikely to disclose negative information about the physician extender.

physician extender in a like manner comparable to that which is done with physicians. Perhaps the only absolute rule concerning physician extenders is that the employer must do its own due diligence work.¹³⁶ Thus, until physician extenders are subjected to the rigors of a more formal education, certification and/or a central data bank profiling scheme, so that objective criteria is established to differentiate one physician extender from another, it is unlikely that there will be any litigation concerning the negligent selection of physician extenders.

In general, “[a] person conducting an activity through servants or other agents is subject to liability for harm resulting from his conduct if he is negligent or reckless . . . in the supervision of the activity.”¹³⁷ However, at present, liability for the negligent supervision of a physician extender turns on specific state law. Some States require that physician extenders work under physician supervision,¹³⁸ while other States will allow physician extenders to work under the supervision of a physician at a geographically remote site.¹³⁹ To trigger liability for negligent supervision of a physician extender, a plaintiff must demonstrate that the lack of supervision is causally linked to the alleged harm.¹⁴⁰ Thus, “a physician must do more than sign an order to be liable for a [physician assistant’s] acts. The physician’s liability must be derived from a direct act or omission to act, such as failing to supervise a [physician assistant].”¹⁴¹ How much more is required is unclear. However, in one case, the court made note of a hospital’s requirement that proper physician supervision of an extender contemplates that the physician

¹³⁶ See *SeaRiver Maritime, Inc. v. Indus. Med. Servs., Inc.*, 983 F. Supp. 1287 (N.D. Cal. 1997) (finding health care provider liable for negligent hiring for failing to inquire into a physicians qualifications and experience); *Voss v. Bridwell*, 364 P.2d 955 (Kan. 1961) (holding that physician must exercise due care in the selection of a resident to provide anesthesia).

¹³⁷ RESTATEMENT (SECOND) OF AGENCY § 213 (1958).

¹³⁸ *Gore*, *supra* note 78, at 133 (citing CAL. BUS. & PROF. CODE § 3516.5 (West 1990); COLO. REV. STAT. § 12-36-106(5)(b)(I) (1997); GA. CODE ANN. § 43-34-103(d) (1994); 225 ILL. COMP. STAT. 95/7 (West 1998); LA. REV. STAT. ANN. § 1360.31(A)(1) (West 1994); MD. CODE ANN., HEALTH-GEN. I, § 15-301(a) (1994)).

¹³⁹ *Id.* (citing NEB. REV. STAT. § 71-1, 107.17(b) (1996); S.D. CODIFIED LAWS § 36-4A-19(3) (Michie 1999); WASH. REV. CODE § 18.71A.020(2)(b)(ii) (1999)).

¹⁴⁰ *Id.* at 134.

¹⁴¹ *Id.* at 129.

will review more than ten percent of the extender's work product.¹⁴²

2. Vicarious Liability: Respondeat Superior

Because physician extenders are statutorily required to work under physician supervision, the extenders almost always stand in an employer-employee relationship with their physician supervisors.¹⁴³ This employment relationship forms the basis for applying respondeat superior liability upon the employer.¹⁴⁴

In order for a plaintiff to successfully sue a physician on a respondeat superior claim he must show that the tortfeasor was acting on the physician's orders and that the physician had a right of control over the tortfeasor's actions. It is by the right to control the manner of performance that plaintiffs routinely prove the existence of an employee-employer relationship.¹⁴⁵

Whether an employment relationship exists therefore turns on five factors considered in determining the master's degree of control over a servant: "(1) the selection and engagement of the servant; (2) the payment of wages; (3) the power to discharge; (4) the power to control the servant's conduct; and (5) whether the work is a part of the regular business of the employer."¹⁴⁶ However, because many States have statutes requiring a physician supervise the extender, there is generally sufficient control to apply respondeat superior liability.

Two exceptions to the rule that the physician employers will have respondeat superior liability for the actions of subor-

¹⁴² See *MacDonald v. United States*, 853 F. Supp. 1430, 1438 (M.D. Ga. 1994).

¹⁴³ The relationship may not however be entirely linear. The physician supervisor may be a medical director of larger business organization. See *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1495 (demonstrating how the supervisor may be a medical director of a large business organization).

¹⁴⁴ See, e.g., James H. Cook, Note, *The Legal Status of Physician Extenders in Iowa: Review, Speculations, and Recommendations*, 72 IOWA L. REV. 215, 232 (1986) (noting that if a physician extender is found to be an employee of a physician, the physician will be liable under the doctrine of respondeat superior).

¹⁴⁵ Lynn D. Lisk, *A Physician's Respondeat Superior Liability for the Negligent Acts of Other Medical Professionals—When the Captain Goes Down Without the Ship*, 13 U. ARK. LITTLE ROCK L. J. 183, 187 (1991) (citation omitted).

¹⁴⁶ Gore, *supra* note 78, at 136 (citing *Keitz v. Nat'l Paving & Contracting Co.*, 134 A.2d 296, 301 (Md. 1957)).

dinate physician extenders exist.¹⁴⁷ The doctrine of Captain of the Ship provided “patients a theory of recovery for negligent acts performed by hospitals and staff that were shielded by charitable immunity. The courts reasoned that physicians and surgeons were not just the best source for recovery for injured patients, but more importantly, were the only source of recovery.”¹⁴⁸ The legal importance of this doctrine has waned due to the abolition of charitable immunity by *Darling*,¹⁴⁹ and the Borrowed Servant Rule, the other major exception to respondeat superior liability. Under the Borrowed Servant Rule a physician extender who was “directed or permitted by his master to perform services for another may become the servant of [the other physician] in performing the services.”¹⁵⁰ Thus when a physician directs a hospital employed physician extender, the hospital’s respondeat superior liability is severed under the Borrowed Servant Rule.¹⁵¹ However, even under the Borrowed Servant doctrine if the employee physician extender negligently performs a routine clerical act, one that does not require masters-level training in health care, courts are still willing to find respondeat superior liability.¹⁵²

Notice should be taken that respondeat superior liability and liability for negligent supervision, in combination, are powerful weapons to provide compensation for worthy patients who are injured by the negligent acts of a physician extender. If the conduct of the physician extender is too tightly controlled, the supervising physician/employer will be vicariously liable under the doctrine of respondeat superior, but if the conduct of the physician extender is too loosely controlled, the supervising physician/employer will be directly liable for negligent supervi-

¹⁴⁷ The exceptions to respondeat superior liability are not applicable to certain nondelegable duties. “As a result of a nondelegable duty, the responsibility or ultimate liability for proper performance of a duty cannot be delegated, although actual performance of the task required by a nondelegable duty may be done by another.” *Id.* at 138 (citing *Swierczek v. Lynch*, 466 N.W.2d 512, 520 (Neb. 1991)). In essence then, nondelegable duties constitute an exception to the exceptions to respondeat superior liability.

¹⁴⁸ *Id.* at 139.

¹⁴⁹ See *infra*, Part V(A)(1).

¹⁵⁰ RESTATEMENT (SECOND) OF AGENCY § 227 (1957).

¹⁵¹ See *Oberzan v. Smith*, 869 P.2d 682, 685 (Kan. 1994) (holding that the doctrine of respondeat superior did not apply to relationship between hospital technician and radiologist).

¹⁵² See *Gore*, *supra* note 78, at 138.

sion.¹⁵³ However, a patient injured by the negligent act of a physician extender may still go uncompensated.¹⁵⁴

3. Vicarious Liability: Ostensible Agency

Liability under the doctrine of ostensible agency arises when: (1) the plaintiff had reasonable belief in agent's authority; or, (2) that such belief was generated by the holding out by acts or a neglect of the ostensible principal; or, (3) the plaintiff justifiably relied upon a representation of authority.¹⁵⁵ While courts have commonly found hospitals vicariously liable for the negligent conduct of members of the medical staff,¹⁵⁶ only a few cases have been reported that concern ostensible agency liability for physician extenders. For the most part, hospitals have not been found vicariously liable under this doctrine because the plaintiffs constantly "failed to raise a fact issue on each element of ostensible agency."¹⁵⁷

There appears to be three reasons why plaintiffs fail to provide sufficient facts concerning their relationship with a physician extender to survive summary judgment. First, because physician extenders ultimately cannot practice without some supervision, the use of respondeat superior/negligent supervision eliminates the need to demonstrate that a hospital or other business organization provided an affirmative assertion that the physician extender was an agent and as such, that the plaintiff's belief was justified. Second, because a medical malpractice action against a physician extender retrospectively reviews the care given, the plaintiff's testimony contains "would-be assumptions, and 'had I known'" logic.¹⁵⁸ Such arguments undercut the plaintiff's credibility and make a demonstration of justi-

¹⁵³ See *id.* (discussing the effect of the administrative and clerical act rules on physician liability).

¹⁵⁴ See *infra*, Part IV(D)(1) & Part V(B).

¹⁵⁵ See *Drennan v. Cmty. Health Inv. Corp.*, 905 S.W.2d 811, 820 (Tex. App. 1995).

¹⁵⁶ Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 388 (1994).

¹⁵⁷ See *e.g.*, *Drennan*, 905 S.W.2d at 821 (discussing similarity between this case and *Nicholson v. Mem'l Hosp. System*, 722 S.W.2d 746 (Tex. App. 1987), where plaintiffs had failed to raise a factual issue on each element of ostensible agency); *Accord Lopez v. Cent. Plains Reg'l Hosp.*, 859 S.W.2d 600, 605 (Tex. App. 1993); *Jeffcoat v. Phillips*, 534 S.W.2d 168, 172-73 (Tex. App. 1976).

¹⁵⁸ *Drennan*, 905 S.W.2d at 821.

fiable reliance almost impossible.¹⁵⁹ Finally, because most physician extenders do not carry professional liability insurance, plaintiff's attorneys often do not name physician extenders as defendants.¹⁶⁰

D. Limitations in the Current Physician Extender Liability System

The traditional justification for medical malpractice liability, whether it is applied to physicians or physician extenders, has been the value of corrective justice.¹⁶¹ "Traditionally, control—and therefore blame—rested with individual physicians."¹⁶² But, as the above discussion on physician extender liability demonstrates, a "net" of legal theory involving direct physician extender liability and vicarious liability has been developed to catch negligent physician extenders and to provide compensation. But, just as any net has a limited capacity to hold its contents, the net of liability for physician extenders has a limited capacity to provide for corrective justice. Specifically, the current system allows for otherwise worthy patients who have been injured by negligent physician extender care to go

¹⁵⁹ See *id.* (holding that such 'had I known' testimony amounts to no more than conjecture or speculation). In granting summary judgment for the defendant, the *Drennan* court found that the plaintiff failed to place any material facts in controversy despite the following testimony concerning CRNA Ben Harmon who allegedly administered anesthesia negligently to a child:

Ben Harman came in to the room while we were there. I remember that he stood at the foot of Amy's bed, introduced himself as Ben Harman and told us that he was going to be putting Amy to sleep and he asked if anyone had any questions. I do not recall that Amy or any family member asked any questions. . . . I had no idea that Highland Hospital was using CRNAs in the anesthesia department. . . . No one, including Ben Harman, told me or Amy or any member of the family, in my presence, that Ben Harman was a CRNA and not an M.D. anesthesiologist. It was my assumption that he was a physician. Had anyone told us that he was a CRNA before Amy's surgery, I would have told Sharon Drennan that she should not let a CRNA be involved in Amy's care and that she should request an M.D. anesthesiologist to provide the anesthesia care at all times.

Id.

¹⁶⁰ Interview with Karolyn M. Scanlon, underwriter, Kansas Medical Mutual Insurance Company, Topeka, Kansas (April 18, 2001). The reason for why physician extenders often go "bare" with respect to insurance coverage is explained further in the next subsection.

¹⁶¹ Abraham & Weiler, *supra* note 156, at 399.

¹⁶² William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, LAW & CONTEMP. PROBS., Spring 1997, at 159, 195.

uncompensated when the negligence occurs within the scope of the underinsured physician extender.

1. Liability for Negligent Medical Care: Within the Scope of a Physician Extender and Outside of Direct/Continuous Physician Supervision Belongs Exclusively to the Physician Extender

*Oberzan v. Smith*¹⁶³ illustrates that when physician extenders provide a medical service that is within the scope of their practice, liability for medical negligence can be as personal as it is for physicians. In need of a diagnostic barium enema, Katherine Oberzan went to Maude Norton Memorial Hospital where an x-ray technician, who was nominally under the supervision of a staff radiologist, negligently inserted the enema catheter and perforated Katherine's rectum.¹⁶⁴ At the time Katherine's rectum was perforated, the radiologist was not in the room. It was uncontroverted that the x-ray technician was trained to insert the enema catheter and that when the catheter was inserted, the instrument was in the exclusive control of the technician. The trial court dismissed the action against the radiologist because the technician was an employee of the hospital and thus, respondeat superior liability did not exist.¹⁶⁵

On appeal, the plaintiff demurred and asserted that the radiologist should be liable under the doctrine of 'captain of the ship.'¹⁶⁶ But, the court observed that the key to liability was an agency relationship, which requires a factual demonstration that the principle has the ability to control the agent.¹⁶⁷ Unfortunately, the plaintiff could not demonstrate the prerequisite control to trigger an agency relation. The plaintiff admitted that preparation of the patient, including the insertion of the catheter, was not routinely done under the direct (visual) supervision of the radiologist.¹⁶⁸ Moreover, the plaintiff could not cite any statute that imposed a duty on the radiologist to directly supervise the technician. Because the plaintiff could not demonstrate that radiologist was in a position to control the technician's actions, the court upheld the trial court's grant of summary judgment against the radiologist.

¹⁶³ 869 P.2d 682 (Kan. 1994).

¹⁶⁴ *Id.* at 683-84.

¹⁶⁵ *Id.* at 684.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.* at 685.

¹⁶⁸ *Id.* at 685.

It is important to realize that the majority of physician extenders practice their art and provide medical service in same manner as the radiology technician in *Oberzan*: within the scope of their practice, but out of direct visual and auditory control of the physician, who is nominally responsible for the care that is rendered. For care rendered by physician extenders independent of direct physician supervision, courts have held that extenders liability is personal. Thus, cases like *Oberzan* effectively cut off otherwise worthy plaintiffs from compensation by anyone other than individual health care providers. It is in cases like *Oberzan*, that the courts have fashioned the doctrine of corporate liability.¹⁶⁹

2. Physician Extenders as a Group Are Under-Insured

The key to understanding *Oberzan* and physician extender cases like it requires the application of behavioral economic theory.¹⁷⁰ That is, one must contemplate what drove the plaintiff's attorney to doggedly pursue liability against the radiologist when it would appear that the malpractice case against the physician extender was straightforward.

Kansas, like other States, exercises its police power by requiring that all health care providers obtain a license to practice their profession.¹⁷¹ However, while Kansas requires that all physicians carry medical liability coverage, virtually all physician extenders are under no obligation to obtain any professional liability coverage. Specifically, while the insurance code stipulates that professional liability insurance "shall be maintained . . . as a condition to rendering professional service as a health care provider in this state,"¹⁷² the code then exempts

¹⁶⁹ While the doctrine of corporate liability will be discussed further *infra* Part IV, consider *Denton Reg'l Med. Ctr. v. LaCroix*, 947 S.W.2d 941, 950-56 (Tex. App. 1997). *Denton* concerned a misadventure during the delivery of a child. In contrast to the hospital's policy, which required the supervision of an anesthesiologist, when a CRNA administered anesthesia, there was no physician at the time the plaintiff was administered anesthesia. The court held that the hospital was directly liable under the corporate liability doctrine for injuries caused by the failure of physicians to properly supervise the certified registered nurse anesthesiologists according to hospital policy. *Id.*

¹⁷⁰ See Louis Uchitelle, *Following the Money, But Also the Mind: Some Economists Call Behavior a Key*, N.Y. TIMES, Feb. 11, 2001, at C1 (observing the mantra of the nascent field of behavioral economics is "follow the money").

¹⁷¹ KAN. STAT. ANN. § 65-2803(a) (1992).

¹⁷² *Id.* § 40-3402(a).

from the definition of health care providers: physician assistants, podiatrists, optometrists, pharmacists, and advanced practices nurses.¹⁷³ The only physician extenders that are statutorily required to maintain a professional liability policy in Kansas are the CRNAs. Therefore, unless a physician extender is conscientious, the physician extender is under no legal obligation to obtain professional liability.¹⁷⁴ Consequently, most physician extenders are uninsured or at best covered under a global umbrella policy purchased by the supervising business organization.¹⁷⁵

3. Are Physician Extenders Cost-Effective Health Care Providers?

The fact that most physician extenders practice caregiving without professional liability coverage raises the issue of whether the Institute of Medicine's vision of health care delivery is realistic. *Crossing the Quality Chasm* advocates that our health care delivery system fundamentally change from one based on autonomous physician practice to a system based on a collaborative multidisciplinary approach. To accomplish this goal, the Institute of Medicine advocates that the scope of practice physician extenders be expanded.¹⁷⁶ Physician extenders, it is argued, provide medical care as well as physicians and are more cost effective.¹⁷⁷

However, liberalizing the scope of practice of physician extenders and providing more health care by physician extenders only adds another layer of complexity to our health care system. Added complexity means that there will be more hand-offs and communication errors because the ultimate decisionmaker, the physician, will be one step removed from the patient and the patient will be receiving medical care from less qualified individuals.¹⁷⁸ "A recent study of intensive care concluded that adverse events were common and that more than one-fourth of them were due to misunderstandings between hospital staff members or administrative errors."¹⁷⁹ The Institute of Medicine

¹⁷³ *Id.* § 40-3401(f).

¹⁷⁴ Interview with Carolyn M. Scanlon, *supra* note 160.

¹⁷⁵ *Id.* As used here "business organization" could be a physician, physician group, hospital, or insurance company.

¹⁷⁶ *QUALITY CHASM*, *supra* note 1, at 210-11.

¹⁷⁷ *See supra* Part IV.

¹⁷⁸ *See supra* Part IV.

¹⁷⁹ Sage, *supra* note 162, at 167 n.32.

itself has recognized that problems with patient care handoffs are a leading cause of medical errors.¹⁸⁰ Therefore, it is reasonable to conclude, absent evidence to the contrary, that a collaborative multidisciplinary health care delivery system will have at least as many medical errors (if not more) as the current autonomous physician-based system.¹⁸¹

Thus, by merely shifting health care delivery to providers whose formal training is limited to a masters degree, it is unreasonable to expect that the medical error rate with its intended consequences of bodily injury will be attenuated. But what will occur with multidisciplinary health care delivery is that more patients will receive no compensation when a provider harms a patient because under the current system physician extenders are not carrying professional liability insurance. Resolution of this dilemma will take more than merely amending the state insurance codes to mandate physician extenders carry that insurance. Because the insurance industry views physician extenders as having limited exposure to medical malpractice liability, the medical malpractice carrier set the physician extender's premium at a fraction of what they charge their physician counterparts for providing the same service.¹⁸² If this perception of physician extender exposure were to change, which mandating insurance coverage alone would do, then the medical malpractice carriers would, without question, substantially increase the premiums of the physician extenders.¹⁸³ As a consequence of physician extender premiums rising, the extent of physician extender health care would also increase. This fact has been under appreciated.¹⁸⁴

¹⁸⁰ See QUALITY CHASM, *supra* note 1, at 28 (discussing how care delivery processes, including handoffs, "slow down the care process and decrease rather than improve safety").

¹⁸¹ However, as will be discussed *infra*, if the multidisciplinary team approach to health care delivery is coupled with adoption of enterprise liability, there will be financial incentives appropriate to reducing medical errors, even with a greater proportion of health care delivery being provided by physician extenders.

¹⁸² Interview with Karolyn M. Scanlon, *supra* note 160.

¹⁸³ *Id.*

¹⁸⁴ The fundamental problem of economic analysis is how comprehensive the scope of review should be. Only limited discussion is available specifically on the cost benefits of enterprise liability. See Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 503-04 (1997) (discussing arguments that justify channeling liability to managed care providers or hospitals through organizational liability).

By advocating that individual professional liability insurance be supplanted by either enterprise liability coverage or no-fault coverage for medical negligence, *Crossing the Quality Chasm* implicitly recognizes that shifting to a collaborative multidiscipline health care delivery system will not completely reduce medical errors.¹⁸⁵ Both have the advantage that they would provide incentives to reduce medical errors. While a discussion of no-fault insurance medical liability insurance is largely beyond the scope of this article, a few comments are in order.

No-fault insurance does not advance one of the principles of the Institute of Medicine's error reduction program. No-fault insurance will not eliminate the "blame game" because no-fault medical malpractice coverage will necessarily have to determine who is at fault.¹⁸⁶ To understand why no-fault medical malpractice coverage must find fault, one has to realize that no-fault medical malpractice liability coverage will, of necessity, still dissect all cases of alleged medical malpractice to determine whether the cause of injury was due to either the underlying disease state or medical negligence. The reason is rather simple: a medical malpractice liability carrier is not going to be willing to pay out on a claim where the cause of the injury was progression of the underlying disease state.¹⁸⁷ In the way of contrast with no fault automotive insurance, the only form of large-scale no-fault insurance available in this country,¹⁸⁸ an independent variable like disease state does not exist. Thus, even with no-fault medical malpractice coverage, carriers will continue to defend medical malpractice claims in the same high-cost manner.¹⁸⁹ While David M. Studdert has predicted modest

¹⁸⁵ See QUALITY CHASM, *supra* note 1, at 218-19 (noting that enterprise liability and no-fault compensation also could produce an environment more conducive to uncovering and resolving quality problems).

¹⁸⁶ McLean, *supra* note 6.

¹⁸⁷ Interview with Carolyn M. Scanlon, *supra* note 160.

¹⁸⁸ No-fault medical malpractice insurance in New Zealand has been plagued with multiple problems. More information can be found at the Accident Compensation Corporation's web site at <http://www.acc.co.nz> and New Zealand's Department of Labour Accident Insurance web site at <http://www.tocover.govt.nz>. The Swiss government, in contemplating a new course for their national health care policy, does not contemplate provider liability coverage. More information can be at <http://www.swiss-q.org>.

¹⁸⁹ See Abraham & Weiler, *supra* note 156 (referring to the fact that it is the medical malpractice carrier who is on the line in medical malpractice litigation, not the doctor).

cost benefits for health care delivery from a shift to no-fault insurance, it is unclear from his publication how passively he assumed the medical malpractice carriers would be in future litigation.¹⁹⁰ Clearly, the scope of investigation and vigor that a party expects to pursue in no-fault litigation will heavily influence the cost of health care.¹⁹¹

V. ENTERPRISE LIABILITY: THE MEDICAL SERVICE INDUSTRY'S ANALOGUE TO PRODUCE LIABILITY

Crossing the Quality Chasm is not the first report to Congress advocating the adoption of enterprise liability,¹⁹² which is a method to shift liability for adverse events, occurring during the delivery of health care, from the individual physician to the business organization that provided the medical service.¹⁹³ However, although enterprise liability is conceptually no more than a natural extension of corporate liability, enterprise liability is a slippery concept because of polymorphic definitions. However, if enterprise liability is defined as a system under which a business organization that provides a medical service is the exclusive bearer of liability for all medical negligence,¹⁹⁴

¹⁹⁰ See David M. Studdert et al., *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 IND. L. REV. 1643, 1646 (2000); David M. Studdert et al., *Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?*, LAW & CONTEMP. PROBS., Spring 1997, at 1, 25-29.

¹⁹¹ Cf. PAT MILTON, IN THE BLINK OF AN EYE: THE FBI INVESTIGATION OF TWA FLIGHT 800 (1999) (demonstrating the difference in the level of investigation required when a specific causation rather than general causation needs to be demonstrated). Early on in the investigation of the crash of Flight 800, the National Transportation Safety Board [NTSB] determined that the flight had crashed after a center fuel tank exploded. The NTSB thought it appropriate at that point to terminate the investigation, because from its prospective the NTSB only needed to propose improve safety regulations to prevent future similar events. However, the FBI pursuing a criminal investigation had to know the precise cause of the fuel tank explosion pushed the NTSB to virtually reconstructing the entire plane. Similarly, no-fault professional insurance implicitly assumes that investigation into the ultimate cause of medical injury can be truncated. However, like the FBI, no-fault medical malpractice insurance carriers will have a different point of view, which may vitiate the implicit assumption in David Studdard's calculations. See Studdert et al., *supra* note 190.

¹⁹² See PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REPORT TO CONGRESS at 299 (1994).

¹⁹³ Sage, *supra* note 162, at 159; Sharon M. Glenn, Comment, *Tort Liability of Integrated Health Care Delivery Systems: Beyond Enterprise Liability*, 29 WAKE FOREST L. REV. 305, 306-06 (1994).

¹⁹⁴ This definition is consistent with other definitions for enterprise liability in the literature. See *infra*, Part V(B).

regardless of the provider's status, then enterprise liability is the superior method by which to assign liability if physician extenders are to be granted greater autonomy. Moreover, by focusing all litigation against a single party, it is hoped that enterprise liability is a more just and cost efficient system than the traditional indemnity medical malpractice system."¹⁹⁵ Herein, however, we are only concerned with the concept, and not the details of enterprise liability.¹⁹⁶

A. Origins of Enterprise Liability

Traditionally, liability for medical malpractice was personal. Because physicians were viewed as autonomous decisionmakers,¹⁹⁷ and business organizations were prohibited by statute from the practice of medicine,¹⁹⁸ the hospital and other business organizations were initially viewed as being a step removed from patient care. Accordingly, hospitals and other business organizations could not be found liable for any patient harm.¹⁹⁹ Moreover, hospitals traditionally were considered to have received an implied waiver of immunity from liability by providing medical treatment, without remuneration, under the doctrine

¹⁹⁵ See E. Haavi Morreim, *Playing Doctor: Corporate Medical Practice and Medical Malpractice*, 32 U. MICH. J.L. REFORM 939, 973 (1999) (discussing that under an enterprise liability theory, health care plans would bear all liability, including medical malpractice because they are the "best locus of responsibility").

¹⁹⁶ See Abraham & Weiler, *supra* note 156, at 404-06 (suggesting that enterprise liability would work like a workman's compensation system with scheduled compensation). We are not concerned with such limits. Similarly, alternative dispute resolution could be part of enterprise liability. Sage, *supra* note 162, at 189-91. Yet, U.S. Supreme Court jurisprudence may prove important to the arbitration of medical malpractice claims. In *Doctor's Assocs., [sic] v. Casarotto*, the Court held that the Federal Arbitration Act preempts state laws requiring arbitration agreements to contain elements such as bold-face type, mandatory disclosure, or rescissionary periods that are not applicable to other contracts.

Id. at 191 (citation omitted).

¹⁹⁷ See *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914) ("[T]he physician occupies the position . . . of an independent contractor, following a separate calling"), *overruled by* *Bing v. Thunig*, 143 N.E.2d 3, 8 (N.Y. 1957).

¹⁹⁸ PATRICIA F. JACOBSON, *Prohibition Against Corporate Practice of Medicine: Dinosaur or Dynamic Doctrine?*, in 1993 HEALTH LAW HANDBOOK 67-69 (Alice G. Gosfield ed., 1993).

¹⁹⁹ See *Benedict v. Bondi*, 122 A.2d 209 (Pa. 1956) (noting that under the "Captain of the Ship" doctrine, even nursing activities were not hospital action but rather an action done at the discretion of a physician), *overruled by* *Thompson v. Nason Hosp.*, 527 Pa. 330 (1991).

of charitable immunity.²⁰⁰ However, the calculus concerning liability changed after World War II with the commercial introduction of medical insurance,²⁰¹ which forever changed the view of business organizations in health care delivery.²⁰²

1. Hospital Liability

The watershed case that applied corporate liability to hospitals and abolished charitable immunity, thereby making hospitals liable for the quality of medical care delivered within its walls, was *Darling v. Charleston Community Memorial Hospital*.²⁰³ Mr. Darling developed complications after having been hospitalized for the treatment of a broken leg. Because his complications were not detected in a timely manner, Darling eventually had to have a major amputation. The hospital was found to be directly and vicariously liable because its nursing staff had failed to detect Darling's deteriorating condition.²⁰⁴ In reaching its holding, the *Darling* court applied corporate liability theory to the hospital. Under this theory, it was the "hospital's own negligence—not the negligence of its non-employee medical staff" that triggered the hospital's liability.²⁰⁵ Corporate liability

²⁰⁰ See, e.g., *McDonald v. Mass. Gen. Hosp.*, 120 Mass. 432 (1876) (finding that public charitable hospital was not liable for injury to patient caused by their negligence).

²⁰¹ The concept of medical insurance was first introduced to the public on a limited basis during the Depression.

²⁰² See generally *Abraham & Weiler*, *supra* note 156, at 385 (introducing the legal and economic evolution of the hospital to enterprise liability).

²⁰³ 211 N.E.2d 253 (Ill. 1965).

²⁰⁴ *Id.* at 256.

²⁰⁵ *Craig W. Dallan, Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 621 (2000). Darling's application of direct corporate liability was a natural extension of the principle that hospitals were vicariously liable for the action of their employees under the doctrine of respondeat superior. See *Bing v. Thunig*, 143 N.E.2d 3, 8 (N.Y. 1957) (finding hospital liable for nurse's negligent application of an antiseptic that resulted in a chemical burn). It is . . . a non sequitur to conclude that because a hospital cannot practice medicine or psychiatry, it cannot be liable for the actions of its employed agents and servants who may be so licensed." *Sloan v. Metro. Health Council of Indianapolis, Inc.*, 516 N.E.2d 1104, 1108 (Ind. Ct. App. 1987). Hospitals have also been found to be vicariously liable for non-employees under the doctrine of ostensible agency. "Although emergency room treatment is the most prominent setting for apparent- authority claims against hospitals, comparable vicarious liability suits have been successfully launched against hospitals for the alleged negligence of anesthesiologists, radiologists, pathologists, and even occasionally against a surgeon whose services the patient used because he was on the hospital staff." *Abraham & Weiler*, *supra* note 156, at 388. "The tacit premise of courts that impose agency liability on

“imposes an independent duty on the hospital to use reasonable care to scrutinize and verify the (continuing) qualifications of its physicians.”²⁰⁶

Since *Darling*, numerous courts have imposed liability on hospitals for injuries resulting from the negligence of the hospital’s medical and nursing staff.²⁰⁷ However, limits exist as to how far a hospital’s corporate liability extended. “Only the Alaska Supreme Court has explicitly held that the hospital’s legal responsibility for malpractice by its physicians is non-delegable and non-waivable—the same duty that now governs airline liability, for example, even if an airline uses pilots or mechanics on an independent-contractor basis.”²⁰⁸

A key feature of the *Darling* opinion was that third party professional standards—the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) guidelines for accreditation of hospitals—were admissible into evidence to establish the standard of care. Medical guidelines provide a bright line to denote what is appropriate medical care under the same or similar conditions. “Since the early 1970s, the JCAHO has required hospitals to establish programs to improve the quality and appropriateness of patient care.”²⁰⁹ Such corporate activities in-

hospitals based on apparent authority is that patients, so informed, would shop around for hospitals that did employ their physicians.” *Id.* at 389.

²⁰⁶ Abraham & Weiler, *supra* note 156, at 391.

²⁰⁷ Dallan, *supra* note 205, at 620; *See* *Insinga v. LaBella*, 543 So. 2d 209, 213-14 (Fla. 1989) (citing *Darling* and adopting corporate negligence doctrine); *Corleto v. Shore Mem’l Hosp.*, 350 A.2d 534, 539 (N.J. Super. Ct. Law Div. 1975) (finding vicarious liability where hospital contracted with incompetent physician); *Diaz v. Feil*, 881 P.2d 745, 749 (N.M. Ct. App. 1994) (clarifying corporate negligence doctrine adopted in New Mexico); *Bost v. Riley*, 262 S.E.2d 391, 396 (N.C. Ct. App. 1980) (citing *Darling* for hospital’s duty to patient); *Strubhart v. Perry Mem’l Hosp. Trust Auth.*, 903 P.2d 263, 275-76 & n. 13 (Okla. 1995) (reviewing jurisdictions adopting corporate negligence doctrine); *Thompson v. Nason Hosp.*, 591 A.2d 703, 707 (Pa. 1991) (finding hospital liable under corporate negligence doctrine); *Rodrigues v. Miriam Hosp.*, 623 A.2d 456, 462-63 (R.I. 1993) (applying doctrine of corporate negligence where hospital failed to exercise reasonable care selecting staff); *Denton Reg’l Med. Ctr. v. LaCroix*, 947 S.W.2d 941, 950 (Tex. App. 1997) (declaring, under Texas law, hospital may be independently liable for injury); *Pedroza v. Bryant*, 677 P.2d 166, 169-70 (Wash. 1984) (detailing history of corporate negligence theory and adopting corporate negligence); *But see Gafner v. Down East Cmty. Hosp.*, 735 A.2d 969 (Me. 1999) (refusing to adopt corporate liability theory, as formulated in *Darling* and *Thompson*, in cases concerning negligence of hospital staff).

²⁰⁸ Abraham & Weiler, *supra* note 156, at 389.

²⁰⁹ *Id.* at 396.

clude a duty to select and monitor its agents and perform quality assurance audits.²¹⁰

Virtually all [quality assurance] programs employ personnel other than the patient's treating physicians to evaluate, recommend, or require protocols for the care provided by those physicians. . . . [Quality assurance] programs often focus on the overall quality of care provided by a particular hospital, thereby giving the hospital an even more direct stake in the quality of care provided by individual physicians on its premises.²¹¹

The importance of external guidelines like JCAHO standards for corporate liability is that, like a business organization's by-laws, violations of these standards will serve as evidence of breach of the standard of care and thereby may trigger corporate liability.

2. Managed Care Organization Liability

The jurisprudence that governs liability for managed care organizations (MCOs)²¹² evolved in a fashion analogous to hospitals. Initially, MCOs, like the hospitals before them, were insulated from liability for medical malpractice because a physician's conduct was perceived as being independent of MCO control.²¹³ Similarly, no liability inured to the IPA model HMO because physicians providing medical care were "independent contractors."²¹⁴ But, as MCOs began to behave more like hospi-

²¹⁰ See *Elam v. Coll. Park Hosp.*, 183 Cal. Rptr. 156 (Ct. App. 1982) (holding that a hospital has a duty to carefully select and review its medical staff so as to prevent unreasonable risk of harm to its patients); *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156 (Wisc. 1981) (concluding that a hospital owes a duty of care to its patients in investigating and verifying the credentials of its applicants when it is foreseeable that a failure to do so would result in harm to patients).

²¹¹ *Abraham & Weiler*, *supra* note 156, at 397.

²¹² A discussion of the business organization of MCO is beyond the scope of this article. For general information on this topic, see Edward P. Richards & Thomas R. McLean, *Physicians in Managed Care, a Multidimensional Analysis of New Trends in Liability and Business Risk*, 18 J. LEGAL MED. 443 (1997).

²¹³ See *Mitts ex rel Mitts v. H.I.P. of Greater N.Y.*, 478 N.Y.S.2d 910 (N.Y. App. Div. 1984) (holding that a Health Insurance Plan cannot be liable in malpractice for the actions of a physician because the organization did not treat anyone).

²¹⁴ *Raglin v. HMO Ill. Inc.*, 595 N.E.2d 153, 156 (Ill. App. Ct. 1992), *overruled by Petrovich v. Share Health Plan*, 719 N.E.2d 756 (Ill. 1999). Whether physicians were ever truly independent contractors under managed care medicine is debatable. See *Pulvers v. Kaiser Found. Health Plan*, 160 Cal. Rptr. 392 (Ct. App. 1979)

tals in selecting physicians and engaging in quality assurance,²¹⁵ the calculus for MCO liability began to change. Like *Darling*, the liability of the MCO was forever changed by the application of corporate liability under *Jones v. Chicago HMO Ltd. of Illinois*,²¹⁶ which held that MCO's could be liable for "institutional negligence."

In 1992, three-month old Shawndale Jones developed signs and symptom of an acute febrile illness. Her mother called Dr. Jordan, who had been assigned by the HMO to provide primary care for Jones, but he was too busy to take the call. An assistant advised the mother to administer castor oil. The following day the child was worse, so the mother brought Shawndale to an emergency room where the child was diagnosed with "bacterial meningitis, secondary to bilateral otitis media, an ear infection."²¹⁷ Ultimately, the child was permanently disabled by this condition.

Dr. Jones was under a capitation contract to provide care for public aid patients that contained the clause, 'shall provide all Beneficiaries with medical care consistent with prevailing community standards.'²¹⁸ During discovery, it was learned that the HMO was aware that Dr. Jordan was the "only physician who was willing to serve the public aid membership in Chicago Heights."²¹⁹ Accordingly, Dr. Jordan was under contract to provide primary care for over 4500 patients as of Dec. 1, 1990.²²⁰ The medical director for the HMO provided testimony that he believed that HCFA guidelines recommended that only 3500 patients be assigned to a pediatrician.²²¹ In her suit against the

(finding no cause of action against an HMO, which alleged that Kaiser had fraudulently lead the plaintiff into believing that she was receiving the best quality of care).

²¹⁵ The federal government regulates HMO quality through 42 U.S.C. § 300(e)(c)(6) (1994) (providing that every HMO shall establish an ongoing quality assurance program for its health services stressing health outcomes and providing review by physicians and other health professionals).

²¹⁶ 730 N.E.2d 1119, 1128 (Ill. 2000) (explaining that "[i]nstitutional negligence is also known as direct corporate negligence").

²¹⁷ *Id.* at 1123.

²¹⁸ *Id.* at 1126.

²¹⁹ *Id.* at 1125.

²²⁰ *Id.*

²²¹ *Id.*

Federal rules set the appropriate level of financial incentives at no more than twenty-five percent for physicians with a patient panel size of 25,000 or fewer patients. Federal law sets no limits on managed care panels larger than 25,000, on the assumption that physician groups with such larger pan-

HMO, the mother alleged that the HMO was liable for "(1) negligently assigning Dr. Jordan as Shawndale's primary care physician while he was serving an overloaded patient population, and (2) negligently adopting procedures that required Jones to call first for an appointment before visiting the doctor's office or obtaining emergency care."²²² The trial court granted the defendant HMO's summary judgment.

The Supreme Court of Illinois began its analysis by observing that since *Darling*, the court had "acknowledged an independent duty of hospitals to assume responsibility for the care of their patients."²²³ "[A] hospital must act as would a 'reasonably careful hospital' under the circumstances."²²⁴ The court then took notice that in a manner analogous to the changes in hospitals that occurred in the 1950s, MCOs had taken on a greater role of providing medical care in the 1990s.²²⁵ Specifically, MCOs "regularly employ on a salary basis a large staff of physicians, nurses and internes, [sic] as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services."²²⁶ Modern MCOs, "like hospitals, consist of an amalgam of many individuals who play various roles in order to provide comprehensive health care services to their members."²²⁷

For an MCO to provide comprehensive health services, the MCO has to hire (or arrange for) health care providers and provide for oversight for the selection and credentialing of its professional staffs,²²⁸ and utilization review.²²⁹ Accordingly, as in *Jones* state courts began to recognize that MCO's, as employers who pro-

els can adequately spread risk and are therefore not at substantial financial risk.

Furrow, *supra* note 184, at 465-66.

²²² *Jones*, 730 N.E.2d at 1123-24.

²²³ *Id.* at 1128.

²²⁴ *Id.* (quoting *Advincula v. United Blood Servs.*, 678 N.E.2d 1009 (1996)).

²²⁵ *See id.*

²²⁶ *Id.*

²²⁷ *Id.*

²²⁸ *See Sage*, *supra* note 162 (indicating that "selection and credentialing requirements for health plans now approach the level of detail traditionally reserved for hospital medical staffs").

²²⁹ Utilization review is a fundamental insurance process which is an "indirect means to control treatment decisions." Jack K. Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J.L. & MED. 7, 25 (1996). In principle, utilization review "reduces medical costs while providing increased health care alternatives." Glenn, *supra* note 193, at 332.

vided oversight of health care delivery, should appropriately be subjected to liability for their negligent actions.²³⁰ Thus, MCOs could be held directly liable for their negligent failure to adequately select a plan provider²³¹ and to provide utilization review.²³² Moreover, MCOs have been found vicariously liable for the conduct of their employees under the doctrine of respondeat superior.²³³

Thus, the *Jones* court, having determined that the doctrine of corporate negligence was applicable to MCOs, re-examined the law and facts that governed the instant case.²³⁴ “The foregoing principles of law establish that the crucial difference between ordinary negligence and professional malpractice actions is the necessity of expert testimony to establish the standard of care and that its breach was the cause of the plaintiff’s in-

²³⁰ Sage, *supra* note 162, at 174.

²³¹ McClellan v. Health Maint. Org. of Pa, 604 A.2d 1053, 1059 (Pa. Super. Ct. 1992).

²³² See Wickline v. State, 239 Cal. Rptr. 810, 819 (noting that [t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms”).

²³³ See Schleier v. Kaiser Found. Health Plan of the Mid-Atlantic States, Inc., 876 F.2d 174, 177-78 (D.C. Cir. 1989) (finding that an HMO could be held vicariously liable for the actions of an independent consulting physician based on the theory of respondeat superior); Sloan v. Metro. Health Council of Indianapolis, Inc., 516 N.E.2d 1104, 1107-09 (Ind. Ct. App. 1987) (finding that health maintenance organization could not avoid medical malpractice liability under the doctrine of respondeat superior by not incorporating under the Professional Corporations Act); *Contra* Harrell v. Total Health Care, Inc., 781 S.W.2d 58 (Mo. 1989) (holding that a non-profit HMO could not be vicariously liable for patient injuries because it was a “health services corporation” protected from such liability by statute); *Cf.* Mitts v. H.I.P. of Greater N.Y., 478 N.Y.S.2d 910, 911 (N.Y. App. Div. 1984) (holding that a defendant that sells insurance rather than practice medicine could not be held vicariously liable for the medical malpractice of independent contractors). Although MCO liability was initially limited to the staff model MCO, because courts “relied on a statutory provision permitting corporations to render professional services to hold that an HMO’s staff physicians are not independent contractors,” liability was quickly expanded to less integrated form of MCOs. Kilcullen, *supra* note 229, at 29. Ultimately the courts have even held that an MCO could be held vicariously liable for the medical malpractice of its independent-contractor physicians under both the doctrines of apparent authority and implied authority. See Petrovich v. Share Health Plan of Ill., Inc., 719 N.E.2d 756, 775 (Ill. 1999); see also Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc., 958 F. Supp. 1137, 1150 (E.D. Va. 1997) (finding that ERISA did not preempt state law medical malpractice claims against health maintenance organizations based on physicians’ alleged negligence in diagnosing and treating an ERISA plan participant’s brain tumor).

²³⁴ Jones v. Chicago HMO Ltd. of Ill., 730 N.E.2d 1119, 1129 (Ill. 2000).

jury.”²³⁵ Again, citing *Darling*, the court opined that corporate negligence could be treated as ordinary negligence, especially in cases where there were independent guidelines.²³⁶ Thus, expert testimony was not always required to establish the standard of care in an institutional negligence action. The “standard of care required of a hospital in a case of institutional negligence may be shown by a wide variety of evidence, including, but not limited to, expert testimony, hospital bylaws, statutes, accreditation standards, custom and community practice.”²³⁷ The Chicago HMO’s own medical director had testified that Dr. Jordan had been assigned patients in excess of the federal guidelines, which was sufficient to establish breach of the standard of care.²³⁸ As for causation, the court stated it could

easily infer from this record that Dr. Jordan’s failure to see Shawndale resulted from an inability to serve an overloaded patient population. A lay juror can discern that a physician who has thousands more patients than he should will not have time to service them all in an appropriate manner.²³⁹

Thus, the court held that even without expert testimony, there was a genuine dispute between the parties. Accordingly, the trial court erred when it granted summary judgment for the defendant.²⁴⁰

3. Limitation of Corporate Liability

The above discussion indicates that existing law imposes direct liability upon institutional providers of health care services regardless of whether the health care is provided within the walls of a hospital or coordinated under the aegis of the MCO medical director in a distant city. Thus, a threshold question to proposing the adoption of enterprise liability, in any form, is why is this needed if institutional providers are already subjected to direct corporate liability? The answer is that corpo-

²³⁵ *Id.* at 1130.

²³⁶ *Id.* at 1130-31.

²³⁷ *Id.* at 1131.

²³⁸ *Id.* at 1132.

²³⁹ *Id.* at 1133.

²⁴⁰ However, the court upheld the trial court granting of summary judgment on the basis of negligent appointment procedures because the plaintiff had not provided expert testimony that would be required to set the standard of care. *Id.* at 1135.

rate and agency liability theories, as they apply to institutional health care, contain many loopholes that allow wrongdoers to escape.²⁴¹ For example, unless the hospital or MCO directly employs the physician extender, if a patient is harmed by the independent act of a physician extender acting within the scope of his practice, the harm may go uncompensated.²⁴² Consequently, the existing corporate and agency liability under the common law "leaves a large penumbra of uncertainty for anxious providers in terms of its case-by-case application of general principles; it encourages liability avoidance or risk-shifting strategies rather than risk management."²⁴³ Thus, while the end results of enterprise liability may be generally possible under other doctrines, including corporate liability,²⁴⁴ advocates of enterprise liability seek a unified doctrine to guide future health care policy. Unfortunately, rather than being a unified doctrine, the current legal literature suggests that enterprise liability is polymorphic and more akin to a field of theories than a discrete doctrine.

B. Enterprise Liability: Beauty Is in the Eye of the Beholder

Paul Weiler and Kenneth S. Abraham originated the concept of enterprise liability, as it applies to health care, in the early 1990s.²⁴⁵ Weiler and Abraham realized at the end of the 1980s that the United States' health care delivery system had become complex; the autonomous solo physician practitioners

²⁴¹ See Abraham & Weiler, *supra* note 156, at 391-92 (listing various examples where corporate liability may be difficult to ascertain due to practical and procedural reasons, such as discovery difficulties).

²⁴² See *supra*, Part IV.

²⁴³ Furrow, *supra* note 184, at 502.

²⁴⁴ See Glenn, *supra* note 193, at 327-38.

²⁴⁵ *Id.* at 309. Enterprise liability, however, has its roots ultimately in product liability. See Kilcullen, *supra* note 229, at 10. Francis Bohlen, "proposed the benefit theory, which treats liability as an internal cost borne by the party benefited by the behavior which put the victim at risk." *Id.* Building on this concept Fleming James observed that the limitation of traditional fault-based tort liability was that it treated parties as economic equals, thereby permitting moral judgment of one party's conduct to deter injurious actions; which was no longer true in industrialized America. *Id.* at 11. James' distributed justice system, whereby a "person nominally liable is often only a conduit through whom this process of distribution starts to flow" forms the bases of enterprise liability. *Id.*

were no longer providing the decisionmaking in our system.²⁴⁶ Health care has become increasingly complex because of the costs of medical services, ERISA's protection of MCOs, and the present shift of health care to the ambulatory setting. At the beginning of the 1980s, hospitals were the pivotal business structure in our health care delivery system. However, by the mid-1980s, double-digit medical inflation, precipitated by the costs of the Vietnam War and the Arab Oil embargo,²⁴⁷ resulted in the federal government's announcement that it would move away from the traditional fee-for-service medical reimbursement scheme.²⁴⁸ Thus, by the end of the 1980s, prospective payment by both the federal government and the insurance companies resulted in payors of medical services gaining hegemony in the medical hierarchy.²⁴⁹ The complexity initially arose because prospective payment schemes fundamentally altered the doctor-patient relationship.²⁵⁰

MCOs directly contributed to the complexity of health care delivery. Furrow argued that even without the increasing use of physician extenders, that enterprise liability is a more appropriate system than the traditional medical malpractice system for redressing adverse medical events. Traditional "tort doctrines focus on the physician while shielding the MCO, federal law

²⁴⁶ See Furrow, *supra* note 184, at 473 (noting that "[b]y 1996, more than a third of physicians were located in group practices of three or more and another third were employees or contractors").

²⁴⁷ See generally Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 435 & n. 6 (1988) (explaining that in the mid 1980s, aggressive new public and private initiatives showed the potential for reining in previously unharnessed health care inflation).

²⁴⁸ See Eleanor D. Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L. J. 1, 33-34 (1987) (reciting recent legislative reforms in an attempt to reduce rising Medicare costs).

²⁴⁹ See Morreim, *supra* note 195, at 975 (stating that the "market-oriented health policy of the 1980s and 1990s could easily give way to heavy-handed government regulation of MCOs unless private-law remedies for torts and breach of contract are perceived to provide adequate deterrence of quality lapses"). "Enterprise liability as a hospital-oriented concept gained little foothold, partly because changing economic conditions soon meant that health plans, rather than hospitals, became the important locus of control over the financing, delivery, and accountability of care." *Id.* at 974. Others have questioned whether hospitals are the fundamental business organization for health care delivery. See Sage, *supra* note 162, at 191 (stating that "hospitals are increasingly peripheral to basic medical care").

²⁵⁰ See McLean & Richards, *supra* note 8, at 34-35 (noting that fee for service schemes encourage the physician to do everything possible for the patient).

reinforces these tort defenses with ERISA preemption, and advocates of managed care further limit remedies through voluntary binding arbitration of disputes, while pushing even further for contractually set standards of care.”²⁵¹ This is especially true in light of the shift in health care delivery to more ambulatory settings. As a result, the “shift toward ambulatory and home-based care is resulting in a greater percentage of malpractice cases with no hospital involvement.”²⁵²

Thus, the financial winds of the 1980s left the federal government and MCOs firmly at the apex of the medical decision-making tree. Hence, because the medical service payors²⁵³ are the “single entity responsible for integrating and coordinating the financing and delivery of services,” they are better suited to the application of enterprise liability than more traditional health care delivery.²⁵⁴ Moreover, by the 1990s, flux in the health care industry made it clear that health care quality is inexorably linked to health care costs.²⁵⁵ To cope with the market changes, Weiler and Abraham recommended that enterprise liability be applied to hospitals.²⁵⁶ But, because it is now clear that health care payors have become the pivotal business organizations in health care delivery, applying enterprise liability to hospitals no longer appears to be appropriate. Thus, as used here, enterprise liability is “a principle which shifts legal responsibility for medical liability from individual providers to health plans with which the patients have contracted.”²⁵⁷ Thus,

²⁵¹ Furrow, *supra* note 184, at 425.

²⁵² Sage, *supra* note 162, at 163.

²⁵³ Herein the term “medical service payor” is used to denote any integrated health plan that coordinates both delivery of and payment for medical services. Thus all MCO plans are medical service payors. But, the term medical service payors is intended to be broader in scope so as to include the federal government because arguably its extensive health care regulations impact the delivery of health care. Moreover, because the federal government is the largest purchaser of health care services, if the Institute of Medicine is successful in revolutionizing health care delivery, it is difficult to see how this can be achieved without having the federal government on board. *Cf.* Kilcullen, *supra* note 229, at 9, (noting that “[t]hrough ERISA the federal government sacrificed fundamental patient protection to encourage the private sector provision of health care and pension benefits”).

²⁵⁴ Furrow, *supra* note 184, at 430.

²⁵⁵ See McLean, *supra* note 6 (noting that the quality of a country’s health care is dependent on what it can afford).

²⁵⁶ Abraham & Weiler, *supra* note 156.

²⁵⁷ Glenn, *supra* note 193, at 306. “‘Enterprise medical liability’ is a term used to describe a system in which health care organizations bear responsibility for

the medical service providers would be analogous to a product manufacturer who places a product into the stream of commerce. How enterprise liability would in actuality be applied to a medical service payor varies with the commentator.²⁵⁸ However, there are basically two forms of enterprise liability in the legal literature.

1. Weiler-Abraham Enterprise Liability

Under the Weiler-Abraham form of enterprise liability all “present-day vicarious, agency, and corporate liability theories” would be used to redress the medically adverse events.²⁵⁹ Under Weiler-Abraham enterprise liability, medical service payors “would be the exclusive bearers of medical liability for all malpractice claims brought by hospitalized patients—regardless of the provider’s status as employee, independent contractor, or holder of admitting privileges, and regardless of the site of the provider’s malpractice.”²⁶⁰ Therefore, under Weiler-Abraham enterprise liability, an injured patient would not have a cause of action against the individual health care provider, whether it be a physician or a physician extender. Weiler-Abraham enterprise liability would, however, not be identical to no-fault insurance coverage, because Weiler-Abraham enterprise liability “would still base liability on documented [provider] malpractice.”²⁶¹ Thus, while Weiler-Abraham fault-based enterprise liability is

medical malpractice in addition to or instead of individual health professionals.” Sage, *supra* note 162, at 159.

²⁵⁸ Conceptually, enterprise liability would have to be applied to the federal government for the Institute of Medicine’s vision of health care delivery to make sense because the federal government is the largest medical service payor. Herein, I am only concerned with how enterprise liability is needed to provide the right financial incentives to improve, rather than degrade, health care delivery. National health care policy is beyond the scope of this article.

²⁵⁹ Abraham & Weiler, *supra* note 156, at 393. Since the publication of this article, the term “hospital” has been replaced with “medical service payor”, as it applies in Abraham and Weiler’s article, in accordance with changes in health care over the last decade.

²⁶⁰ *Id.*

²⁶¹ *Id.* at 414. In reality, Weiler was interested in using enterprise liability as a bridge to no-fault liability. “By making medical causation rather than medical fault the predicate to recovery, no-fault medical compensation would expand the universe of those entitled to compensation. At the same time, this shift of emphasis from fault to cause would simplify certain aspects of the compensation decision and thereby reduce administrative costs.” *Id.* at 432-33 (citation omitted); see generally Studdert et al., *supra* note 190, at 25 (reporting results of no-fault compensation system versus the current tort system).

essentially a derivative cause of action, it is not vicarious liability. Some have implied it is only vicarious liability but this is incorrect.²⁶²

Weiler-Abraham enterprise liability has two significant limitations. First, Weiler-Abraham enterprise liability, which has been advanced as a transitional step to no-fault coverage, is illogical because it favors vicarious-like liability actions over direct claims.²⁶³ As such, Weiler-Abraham enterprise liability is similar to the liability that a hospital and MCO faces under the doctrine of corporate liability. However, unlike the liability of a hospital or MCO under the doctrine of corporate liability, Weiler-Abraham enterprise liability would preclude direct liability actions against a provider in exchange for a more streamlined cause of action. This potentially could mean that a patient injured by a negligent health care provider would be under compensated.

Traditionally, hospitals have not had an incentive to reduce medical errors because it could be financially disadvantageous for the hospital to police its providers. For example, if each year a hospital receives millions of dollars in remuneration for medical services provided under the direction of one of its physicians, it is not in the hospital's financial interest to discipline such a physician even if it knows or should have known the physician was error-prone. In this situation, behavioral economics would dictate that the hospital would not give up a present lucrative revenue stream because of the potential for a smaller future liability. Similarly, if Weiler-Abraham enterprise liability were applied to a medical service payor, there would be little incentive for the medical service provider to discipline a health care provider (whether physician or physician extender) who substantially reduced expenses even if the medical service payor knew or should have known the provider was cutting corners and creating a population of patients at risk of being harmed.²⁶⁴ In short, Weiler-Abraham enterprise liability does

²⁶² See Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 9-10, (2000) (noting that vicarious liability is often advocated under the label 'enterprise liability').

²⁶³ Sage, *supra* note 162, at 186.

²⁶⁴ Arguably this is the present situation with MCOs. Because the employers shop around each year for a bargain premium, the MCO develops a short time horizon. Thus, if the MCO can put off providing a medical service for less than a year, that expense of that service maybe passed on to a different carrier.

not provide the right financial incentive to meet the Institute of Medicine's number one goal for health care: make it safe.²⁶⁵ Rather, Weiler-Abraham enterprise liability appears to be only an interim step to no-fault medical liability coverage as its innovator had intended.

2. Kilcullen Enterprise Liability

Kilcullen, too, recognized that health care delivery is in a flux:

Just as the Nineteenth century market place has been replaced by the almost-Twenty-first century supermarket, the family doctor is gradually relocating to the physician roster of the neighborhood HMO. The only difference is that the layers attenuating the relationship between doctor and patient may not be so apparent as they are between producer and consumer.²⁶⁶

In Kilcullen's view, enterprise liability for health care delivery is entirely analogous to product liability. Thus, even before *Crossing the Quality Chasm* advocated the intercalation of physician extenders into the doctor-patient relationship, Kilcullen advanced three arguments to compel a shift in medical liability coverage from the traditional indemnity, medical malpractice model to enterprise liability. First, "[t]he technical level of design and delivery of health care services is no less daunting than in the manufacture of automobiles"—in both situations the general public is "equipped with only crude indicators of quality. Thus, consumers will never achieve a true position of market parity."²⁶⁷ Second, the concept of "spreading risk through professional liability insurance for the plan's providers is already part of health care delivery."²⁶⁸ Finally, if ERISA medical jurisprudence has taught us anything, "the cost of safety should be internalized to the plan and not . . . externalized to the injured patient."²⁶⁹ Kilcullen observes that assigning liability to the enterprise that produces a product "becomes an economic

²⁶⁵ QUALITY CHASM, *supra* note 1, at 5.

²⁶⁶ Kilcullen, *supra* note 229, at 47.

²⁶⁷ *Id.* at 48.

²⁶⁸ *Id.*

²⁶⁹ *Id.*; see also Edward P. Richards & Thomas R. McLean, *ERISA Preemption and Managed Care Litigation after Pegram v. Herdrich*, NAT'L LAW REV., June 18, 2001, at B8.

incentive to invest in design of safety features, quality control of production, and truth in marketing" because failure to do so would compromise profits.²⁷⁰

Ultimately, the concept that a manufacturer should be held liable for injuries caused by a defective product is premised upon the concept of enterprise liability for casting defective products into the stream of commerce.²⁷¹ Presently, the scope of enterprise liability is so broad that, for dangerous fungible products, a manufacturer may be held liable for "products that cannot easily be traced back to the actual manufacturer."²⁷² In product liability cases, liability does not turn on whether the risk was unforeseeable, but rather whether the risks associated with the product outweigh its benefits.²⁷³ In Kilcullen's view, a medical service is a "product of a network of trained individuals, many of whom have no contact with the patient."²⁷⁴ Like the unsophisticated consumer who purchases a product, "patients lack the bargaining power to negotiate all aspects of treatment."²⁷⁵ Thus, Kilcullen opines "consumers of health care are no less justified in seeking relief from the burden of proving fault than consumers of products, especially because health care

²⁷⁰ Kilcullen, *supra* note 229, at 15; *see also* Greenman v. Yuba Power Prods, Inc., 377 P.2d 897, 901 (Cal. 1963) (stating that the purpose of imposing liability on manufacturing enterprise "is to insure that the costs of injuries resulting from defective products are borne by the manufacturers that put such products on the market rather than by the injured persons who are powerless to protect themselves").

²⁷¹ *See* RESTATEMENT (THIRD) OF TORTS: PROD. LIAB. § 2 cmt. a (Tentative Draft No. 2, 1995) (discussing the rationale behind establishing separate standards of liability for manufacturing defects, design defects and defects based on inadequate warnings); *see also* RESTATEMENT (SECOND) OF TORTS § 402 (1965) (stating that "[a] seller of a chattel manufactured by a third person, who neither knows nor has reason to know that it is, or is likely to be, dangerous, is not liable in an action for negligence for harm caused by the dangerous character or condition of the chattel because of his failure to discover the danger by an inspection or test of the chattel before selling it").

²⁷² Richard E. Kaye, Annotation, "Concert of Activity," "Alternate Liability," "Enterprise Liability," or Similar Theory as Basis for Imposing Liability Upon One or More Manufacturers of Defective Uniform Product, in Absence of Identification of Manufacturer of Precise Unit or Batch Causing Injury, 63 A.L.R.5th 195 (1998).

²⁷³ White v. Caterpillar, Inc., 867 P.2d 100, 105 (Colo. Ct. App. 1993); *see also* Armentrout v. FMC Corp., 842 P.2d 175, 184 (Colo. 1992) (observing that consumer expectations are a relevant factor in risk-utility analysis). This is clearly in accordance with Institute of Medicine's goal that twenty-first century health care be patient driven.

²⁷⁴ Kilcullen, *supra* note 229, at 15. This is in accord with current hospital terminology where departments have been supplanted by "product lines."

²⁷⁵ *Id.*

providers claim a nobler motivation than profiting from the provided service."²⁷⁶ Under the Kilcullen model, all health care providers "would be treated as part of a single enterprise, hospital, or health-care organization, thereby treating such medical enterprises as product liability law now treats other commercial enterprises such as airlines."²⁷⁷

C. Kilcullen's Enterprise Liability: Meeting the Institute of Medicine's Goals to Improve Health Care

If in the twenty-first century health care delivery is to be based upon a multidisciplinary team approach to control health care costs, patients will be receiving a greater proportion of their health care from individuals with less formal training than the current physician providers. Assertions that as a group, physician extenders provided the same quality of health care as physicians are unsupported by hard statistical data. Moreover, collaborative multidisciplinary health care delivery, because it inserts another caregiver between the physician and the patient, of necessity increases the complexity of our health care system, thereby increasing the potential number of handoff errors. Thus, the unassailable corollary of implementation of collaborative multidisciplinary medicine to cut health care costs is that it will be less safe than our autonomous physician-based approach.²⁷⁸

Thus, to maintain our health care at its present quality level, incentives need to be placed into the health care delivery system to encourage physician extenders (and those who employ or contract with physician extenders) to provide quality health care. Financial incentives to provide a "physician level" quality of care in a collaborative multidisciplinary setting do not exist by intent of system. Moreover, it is clear that the traditional liability system does not provide the proper incentives to

²⁷⁶ *Id.* at 11.

²⁷⁷ Furrow, *supra* note 184, at 502. Far from legal theory, early on the Clinton administration attempted to implement such "tort reform." See Sage, *supra* note 162, at 162-63 (discussing a model for enterprise liability that would replace suits against physicians, proposed in 1993 by President Clinton's Task Force on National Health Care Reform). There is more than a passing resemblance between the combination of the Institute of Medicine's vision of twenty-first century health care health care coupled with the mandates of the Health Insurance Portability and Accountability Act and the proposed practice of medicine envisioned in ill-fated the Health Security Act of 1993.

²⁷⁸ The only conceivable reason to increase the proportion of health care delivered by physician extenders is to cut costs.

achieve this goal and, in fact, provides counter-incentives. Specifically, if a physician extender renders care within the scope of the extender's training and not immediately under physician supervision (without question the precise condition the Institute of Medicine intends), then under our traditional system the physician extender is individually and solely liable for any negligent care rendered, just as a traditional physician would be under similar conditions. There is no guarantee that under the facts of a particular case, a legitimately injured patient would prevail in either a direct corporate liability or vicarious liability action against the physician extender's employer. If the physician extender has chosen not to be insured or was inadequately insured, then a patient negligently injured by the physician extender would be under-compensated.²⁷⁹

Under Kilcullen enterprise liability the medical service payor, i.e., the party who ultimately approves all the business decisions that create and perpetuate the financial incentives under which physician and physician extenders would render medical services, would be liable for all negligent medical care rendered. Thus Kilcullen enterprise liability would provide more appropriate financial incentives to align the interests of patients and health care providers than would those presently provided under traditional medical malpractice theories. In this regard, health care payors would have appropriate incentives to see to it that physician extenders are properly credentialed, insured, and supervised.²⁸⁰ "[T]he most valuable insights about medical accidents generated by the [Institute of Medicine's *To Err is Human*] came from the institution's piecing together a series of apparently idiosyncratic incidents to find common patterns in the way that errors by people or equipment occurred."²⁸¹ Medical errors are system errors.²⁸² This means that if we want

²⁷⁹ See *supra*, Part IV.

²⁸⁰ See Morreim, *supra* note 195, at 977 ("If MCOs become solely responsible for adverse medical outcomes, it is reasonable to expect that they will require their physicians to adhere closely to MCO-chosen guidelines.").

²⁸¹ Abraham & Weiler, *supra* note 156, at 412.

²⁸² See *TO ERR IS HUMAN*, *supra* note 2, at 3. In the Institute of Medicine's view, to effectively detect and correct medical errors, a non-punitive culture must be provided to encourage error reporting. Thus enterprise liability has the potential of increasing physician cooperation. See Morreim, *supra* note 195, at 974 (noting that physicians relieved of concerns of individual liability are more likely to engage in cooperative decisionmaking). Enterprise liability will facilitate physician compliance with clinical guidelines. See Sage, *supra* note 162, at 188 ("Specifically, from a li-

to reduce medical errors associated with the inevitable increase in handoff mistakes among physician extenders, the system must bear the responsibility for any errors.²⁸³ Accordingly, to maintain the current quality of care level, all medical service payors need to be given proper incentives to oversee the care provided by physician extenders, as well as physicians. This could better be achieved under enterprise liability rather than more traditional tort theory.

Enterprise liability, by assigning all liability for medical errors to the medical service payor, provides the medical service payor with a strong financial incentive to detect and correct errors in the health care system.²⁸⁴ Under enterprise liability, because medical service payors would be responsible for errors in communication, they would more readily invest in support systems to enhance the amount, quality, and flow of information.²⁸⁵ It is axiomatic that the reason the medical service payor would invest in support systems is not only to avoid ultimate liability for a medical error, but also, to reduce the next provider insurance premium. Such insurance premiums would, like any other insurance, reflect the medical service payor's past experience. A medical service payor that efficiently detects and corrects errors made by physicians and physician extenders would be rewarded with a lower insurance premium. The medical service payor who provide quality medical care would thereby be able to compete more efficiently for patient in the marketplace.

This kind of experience rating has been a long-time feature of business liability and workers' compensation insurance. Because the prices paid by consumers for products and the wages paid to labor tend to be stan-

ability perspective, rule-based cost containment may be preferable to delegated authority using incentive compensation.”).

²⁸³ See generally Lori B. Andrews et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 THE LANCET 309 (1997) (finding that, of 1047 hospital patient studies, nearly 18% experienced adverse events that led to longer hospital stays and increased costs and that these adverse events need to be discussed for the system to function).

²⁸⁴ In addition, “the public may be better protected from incompetent practitioners by the credentialing, disclosure, and quality management activities of managed care organizations than by direct government regulation of individual physicians. In an analogy to enterprise liability, this reasoning has stimulated interest in institutional licensure as a replacement for individual licensure.” Sage, *supra* note 162, at 196 n.182.

²⁸⁵ *Id.* at 167.

andardized in their respective markets, safer firms make a profit and dangerous firms incur a loss from experience rating. The prospect of such profits and losses tends to give firms the incentive to reduce the risks of injury to optimal levels.²⁸⁶

Enterprise liability should not necessarily increase overall health care costs.²⁸⁷ To control costs, medical service payors have increasingly been moving to employ physicians directly or control them to such a degree that an agency relationship would be created. Thus, medical service payors already bear direct and vicarious liability for their physicians' activities.²⁸⁸ "Furthermore, medical groups typically purchase liability insurance as a unit, and many are large enough to substitute self-insurance or off-shore captive subsidiary arrangements for commercial coverage."²⁸⁹ Thus, the added administrative and insurance cost for providing coverage for the physician extender (the physician's agent) should not be onerous. Moreover, because insurance premiums are "invariably experience-rated"²⁹⁰ and a medical service payor would be larger than any existing physician group (both in number of providers employed and geographic distribution), this greater risk pool means that the medical service payor would pay less per provider than current physician groups for liability coverage. Moreover, many medical service payors "also have the financial wherewithal to self-insure up to high levels of risk, removing any dilutional effect of insurance on deterrence."²⁹¹ In short, given the greater risk, spreading the potential of the medical service payor compared with any physician's group, the medical service payor would be in the best position to shoulder or, in the alternative, provide the financial incentives for the insurance costs associated with the increased utilization of physician extenders.

²⁸⁶ Abraham & Weiler, *supra* note 156, at 409.

²⁸⁷ Mandating that physician extenders all carry liability insurance would not only create a cost for employers of physician extenders that for the most part does not exist at present, but insurance premiums would certainly increase over the current nominal charge because of perceived increased liability exposure. *See* Interview with Karolyn M. Scanlon, *supra* note 160.

²⁸⁸ *See* Sage, *supra* note 162, at 202 (noting that most "medical groups already bear *respondeat superior* liability for their physicians' activities").

²⁸⁹ *Id.*

²⁹⁰ *Id.* at 198.

²⁹¹ *Id.*

VI. CONCLUSION

In *Crossing the Quality Chasm* the Institute of Medicine advocated moving away from the autonomous physician provider model of health care delivery model to the physician extender driven collaborative multidisciplinary model of health care delivery. While the scope of practice for physicians and physician extenders is clearly governed by state law, the federal government, using its power of the purse, is clearly in a position to facilitate a shift in our health care delivery system to the physician extender model. Moreover medical services payors, including the federal government, would clearly benefit from such a shift because physician extenders are willing to provide many medical services at a price substantially less than their physician counterparts. However, shifting to a health care delivery system dominated by physician extenders will likely be more error prone (or at least as error prone) than a physician-driven health care system. Thus, under a collaborative multidisciplinary model of health care delivery, the quality of health care delivered is likely to be compromised. To counteract this shift in quality, adoption of enterprise liability for health care delivery will be necessary since allowing physician extenders to practice under the current medical malpractice system will either result in overall increase in insurance costs or negligently injured patients receiving sub-optimal compensation. While the Institute of Medicine has many excellent ideas about health care delivery, if the country is to “buy-into” any part of the Institute’s health care revolution, one must buy-into the complete package. In short, to ensure that the standard of medical care is not lowered by a national decision to facilitate collaborative multidisciplinary health care delivery, the country must be prepared to move to enterprise liability for health care delivery. When it comes to the vision of health care announced in *Crossing the Quality Chasm*, Gilbert’s remarks are apt: “in for a penny, in for a pound.”²⁹²

²⁹² WILLIAM S. GILBERT, IOLANTHE act 2.

