The Contest for Control: Regulating New and Expanding Health Occupations

RAYMOND G. DEVRIES, PHD

One of the most significant changes in the current health care market is the proliferation of new medical occupations. New types of practitioners (like respiratory therapists and physician assistants) are appearing, and traditional occupations (like nursing and midwifery) are expanding and redefining their practices. Growth in the number and variety of medical occupations poses a challenge to systems used to regulate health personnel. The contest for control of these new occupations results in an assortment of additions and deletions to regulatory law, giving a patchwork quality to the medical practice acts of several states. Practitioners in these new categories struggle to win the legitimacy of state recognition and to defend their autonomy, while the already licensed seek to protect themselves from new occupations that might compete for clientele. As a result, health occupations are tucked here and there under the supervision of new or existing boards of licensure and registration.

Although the "prize" in the contest for control is the privilege of serving the public, the consumer is usually not included in decisions about who should be allowed to provide health services. The predicament brought about by the plethora of regulations provides the opportunity to address the problem of consumer absence in these decisions and to propose creative solutions for regulating health personnel. But it is premature to consider solutions until the problem is thoroughly examined. Specifically, we need to understand the forces generating new occupations and the varied responses to new practitioners.

Proliferation of New Health Occupations

Four trends are producing the steady stream of new health occupations that are pressing claims for licensure:*

- Rapid growth in new medical technologies brings with it a matching number of new technical occupations. In time, these new occupations develop a group identity and begin the quest for the protection of licensure.
- As our population ages and the incidence of chronic disease increases, a host of alternative therapies and practitioners emerge and find support among the older members of society. The search for relief from chronic conditions gives legitimacy to once marginal practices, like acupuncture, and generates new medical subspecialties, like geriatric nursing.
- Renewed concern with the cost of health care has heightened the search for cheaper ways to provide medical service. One of the more promising solutions to the problem of high cost is the use of nurse practitioners, physician assistants, and other mid-level practitioners.
- Challenges to institutional dominance posed in the 1960s and 1970s altered consumer attitudes and demands. Alternative practitioners are attractive to those seeking to participate in their health care and open to nontraditional treatments.

Practitioners of new and newly popular healing arts quickly recognize the need to fit into the system that regulates medicine. Those who stay outside the law governing medical practice have the benefit of remaining true to their own ideals of practice, but suffer loss in job security, miss the benefits of being in referral networks, and, perhaps most importantly, cannot qualify for third party payments.

Those looking for a niche in medical regulations include three main groups: 1) members of currently licensed occupations seeking to upgrade their status (e.g., nurses who are family nurse practitioners); 2) new medical technicians (e.g., respiratory therapists); and 3) unorthodox and unlicensed practitioners (e.g. irridologists). Review of the medical practice acts of the various states reveals that for these occupational groups the game is "capture or be captured." Most new occupations are captured. They gain limited autonomy in an area of practice delegated to them by physicians. Those who are not satisfied with capture struggle to capture their own piece of the medical pie or, in some cases, remain outside the law.

While various segments of the medical care community vie for control formalized in state regulation, there is increased awareness that state law is not the only regulator of the professions. Health personnel are also controlled by lawsuits, the policies of malpractice insurers, and the corporations and hospitals that employ them. New practitioners, and the already licensed, are beginning to realize that the hard won legal right to practice is meaningless if malpractice insurance is not available or if a hospital limits practice or denies privileges.

Responding to New Practitioners: The Case of Midwives

Midwifery offers a good illustration of the problems associated with licensing new and changed health occupations. Because states are given the authority to regulate medical occupations, the rules governing midwives vary widely. This normal variation is compounded by the distinction between certified nurse-midwives (registered nurses with additional training in midwifery) and lay midwives (self-taught midwives who come to the vocation from a variety of backgrounds). A survey conducted by the American College of Nurse-Midwives (ACNM) concluded that the laws governing nurse-midwives were a "patchwork collection . . . a legislative jumble . . . with five different types of jurisdictional agencies [regulating] nurse midwives.[1] A similar hodgepodge governs lay midwives. In some states lay midwives work illegally, violating laws that define assistance at childbirth as the practice of medicine. In those locations, midwives are subject to "reactive regulation": midwives involved in births that come to the attention of the authorities face court prosecution. In other states, midwives have been captured, working under very close physician supervision with little opportunity for independent practice. In still

*Solares A: Changes in the market generate a reevaluation of licensure (unpublished paper).

Address reprint requests to Professor Raymond G. DeVries, Assistant Professor, Department of Sociology, Westmont College, Santa Barbara, CA 93108. The research upon which this report was based was partly funded by the National Science Foundation Law and Social Sciences Program (Grant Number SES-8107980). This column was invited by George J. Annas, JD, MPH, Editor of the Public Health and the Law section of the Journal.

other states, lay midwives are attempting to capture a portion of the health care delivery system by constructing their own licensing laws. The usual strategy involves creating a system of self-regulation and then seeking to get that system written into state law. Examination of each of these situations gives better insight into the predicament of new medical occupations and the clients they serve.

Midwives in the Courts

Lay midwives who work in states with no clear licensing law run the risk of prosecution for violation of the medical practice act. Courts have struggled to clarify the true nature of midwifery: are midwives practicing medicine or providing assistance with a natural and normal life event?

In 1907, the Supreme Judicial Court of Massachusetts suggested that midwifery was the practice of medicine *if* midwives went beyond offering "ordinary assistance in the normal cases of childbirth." The court concluded that if midwifery involved the "occasional use of obstetrical instruments and a habit of prescribing" it "constitutes a practice of medicine in one of its branches."[2] In 1956, the Texas Court of Criminal Appeals reversed the conviction of Diana Banti, a midwife accused of practicing medicine without a license. The court separated assistance at childbirth (a "normal function of womanhood") from the practice of medicine (treatment for "disease, disorder, deformity or injury") and noted that "the Legislature failed to include within the definition of 'practicing medicine' the branch of medical science which has to do with the care of women during pregnancy and partuition . . . [and has] . . . recognized practical obstetrics or midwifery as outside the realm of the medical practice act."[3]

In 1974, several midwives in Santa Cruz, California were arrested and charged with practicing medicine without a license. The California Court of Appeals agreed with the logic of the *Banti* decision and overturned their conviction, deciding that assistance in the normal function of childbirth was not the practice of medicine. But the California Supreme Court overruled the opinion: "We have concluded that normal childbirth, while not a sickness or affliction, is a 'physical condition' within the meaning of . . . section 2141 [of the Business and Professions Code which defines the practice of medicine]. Therefore it is clear that the practice of midwifery without a certificate is prohibited."[4]

Since the court's decision, several of California's lay midwives have been arrested on charges of practicing medicine without a license. A handful of convictions have resulted, with punishments including various combinations of fines, probation, and orders to make restitution. Many lay midwives are seeking protection by getting trained and certified in allied fields already recognized by the law. The nursing practice act in California allows nurses (and hence nurse-midwives and nurse-practitioners) to work in a semi-independent fashion with standardized procedures, "under doctor's orders." If a written protocol is set up defining the parameters of care, specifying when physician intervention is required, these practitioners can legally assist at home births. Midwives who choose this option protect themselves from criminal action, but lose their autonomy by subjecting themselves to the administrative law of the board of nursing and the supervision of physicians.

Some states license nurse-midwives, but do not expressly prohibit lay midwifery. When nurses in those states work as lay midwives, their boards of nursing often seek to claim jurisdiction over their activities. Such was the case with Elizabeth Leggett, a lay midwife and nurse in Tennessee. Her nursing license was revoked when it was learned that she was offering the services of a midwife while not having credentials of a *nurse*-midwife. Her license was restored by an appeals court which stated that the nursing board had no authority over lay midwifery since that practive was allowed by a separate statute.[5]

A similar case was recently heard in the Supreme Judicial Court of Massachusetts.[6] The Board of Registration in Nursing suspended Janet Leigh's nurse license for "at least one year" because she was practicing as a midwife without authorization from the board as a nurse-midwife. Leigh countered that she was practicing as a lay midwife and therefore was not under the board's rightful jurisdiction. The decision of the court was a curious mix of good and bad news. For lay midwives the news was good: the court agreed with the *Porn* decision,[2] concluding that the practice of midwifery (without obstetrical instruments) is not the practice of medicine. For Janet Leigh and other nurses working as lay midwives, the news was bad: the court interpreted existing legislation as requiring all nurses who wish to practice midwifery to be nurse-midwives, thereby justifying disciplinary action against them for violation of nursing regulations.

Courts do not offer the ideal way to regulate midwives. The adversarial process is a slow, costly, and cumbersome means of controlling practitioner behavior. In fact, it is reasonable to assume that this mode of regulation reduces the quality of care. The fear of prosecution discourages midwives from sending complicated cases to hospitals and physicians because they are the most likely sources of legal action against them. Since courts can only react to situations presented to them, there is little opportunity for input from consumer organizations, little opportunity to shape the profession in the interest of the clients it serves.[7] The problems associated with reactive regulation often lead to efforts to license lay midwives.

Licensing Midwives

The most recent compilation of state laws governing lay midwifery indicates that 16 states prohibit the practice, 17 have licensing or registration laws, and 17 have no law which specifically prohibits or allows lay midwives to work.[8] However, the flurry of recent legislative activity centered on lay midwifery calls for constant revision of such information. Since 1980, six states (Florida, South Carolina, Texas, New Hampshire, Washington, and Alaska) passed legislation that creates or updates lay midwife licensure. The legislatures of at least two other states, California and Massachusetts, have considered and rejected licensing laws for lay midwives.

In most cases, efforts to license lay midwifery are initiated by midwives and their clients who view licensure as a means of eliminating the uncertainties and ambiguities of current law. Depending on the political climate and the extent of midwife-assisted home birth, these efforts might be supported or opposed by physician's associations and other professional groups.

Midwives begin their quest with a vision of licensure as the avenue to independent and legally safe practice. Unfortunately, this vision is seldom realized. Licensure frees midwives from the fear of criminal prosecution, but it sharply reduces their independence. Licensure typically places midwives under the control of boards dominated by physicians and nurses. Licensure requires midwives to take examinations created by physicians, covering knowledge

developed by physicians about the birth process. Such examinations rarely test knowledge of non-interventive techniques and other styles of care derived from the tradition of midwifery. Licensure requires training in state-approved programs created and usually approved by physicians. In some cases these requirements sharply reduce or even eliminate the supply of new midwives.

These factors suggest that licensure is not the ideal vehicle for promoting midwifery. Perhaps one generation of midwives, trained in the traditional way with traditional values and "grandmothered in" when new regulations become law, can become licensed and retain their uniqueness. But the licensing process, with formalized training and review procedures, is certain to diminish the alternative character of the profession in time. Nor does licensure eliminate other forms of control. Licensed midwives are faced with the reactive regulation of malpractice, both in the form of suits and prohibitive insurance rates.[9]

Midwives and Self-Regulation

Lay midwives working in states with no provision for licensure, and in states with laws that are unclear, are beginning to set up systems of self-regulation modeled on other professional systems of self-certification. In 1982, the Massachusetts Midwives Association (MMA) began work on a system of self-certification. This voluntary program established competency levels ranging from apprentice to "independent midwife" and set standards for midwives in such areas as screening of clients, essential equipment, continuing education, knowledge, and skills. Information is gathered by means of a "Peer Review Form" that requests data on training and statistics from births attended. The application is reviewed by a committee of midwives. Those who are approved can claim certification by the MMA. The long-range goal is to get state recognition of this self-certification system. If that goal is achieved, lay midwives will succeed in capturing their portion of the medical market.

A less formal version of the same process emerged in California. The issue of peer review came up following complaints about a midwife. The steering committee of the California Association of Midwives (CAM) received a letter of complaint and responded by appointing several midwives to review the midwife and the birth in question. Some midwives supported peer review as a way of ensuring competency and forestalling stricter state regulations. Others saw peer review as potentially divisive and expressed reluctance to pass judgment on another midwife.

Peer review, or self-certification, offers midwives a way of escaping capture by other professions. But from the standpoint of the consumer and public health it might not be an altogether desirable alternative, because it merely exchanges one form of capture for another. Midwives avoid the control of physicians and nurses, but consumers are given little voice in shaping the care they will receive.

Regulatory Capture and the Consumer: Toward Alternative Models

Public health can be enhanced by the wider use of midwives and other new and expanded medical occupations. Several studies have shown the ability of midwives to reach into a community and prevent the problems that lead to low birthweight babies and high infant mortality. Working in a pilot project in California, a group of nurse-midwives moved into the town of Madera, a stopping place for many migrant workers, and greatly reduced infant sickness and death. A recent National Center for Health Statistics study of births of Hispanic parentage shows midwives to have a significantly lower rate of low birthweight babies (under 5 pounds) than physicians.[10]

Maximizing the beneficial effects of these new occupations on the nation's health requires a means of regulating them without diminishing their effectiveness. Reactive control through the courts is inadequate. Reactive control through malpractice also is not desirable. It is not safe to assume that individual malpractice actions or the policies of insurers will minimize cost or maximize quality. The needs of insurance companies rarely and only coincidentally align with the needs of consumers. Licensing legislation results in capture of the occupation by other professions, diminishing the alternative character of the occupation, robbing it of the very things which make it effective.

Systems of self-regulation are perhaps most acceptable, but even these tend to isolate the occupational group, making it less open to consumer input. This sets up a situation where the occupation becomes more concerned with its own needs and less concerned with the needs of those it serves. This tendency manifests itself in several ways. Once licensed, occupational groups often raise the standards for admission. For instance, the American Physical Therapists Association is seeking to require graduate degrees for those entering the profession after 1990, in spite of acceptable performance of currently licensed physical therapists and the anticipated increased costs of this move.[11] Similarly the American Nurses' Association is considering a policy change that would reserve the title "registered nurse" for nurses trained in baccalaureate programs.[12]

Professional associations also are notorious for doing a poor job of dealing with incompetence. Although physicians' associations are often faulted in this score,[13] other health occupations do no better.

To say that regulatory systems tend to protect the profession more than the public is not to imply that professionals are greedy, self-interested people. Freidson suggests that critics of the health care system have become so preoccupied with identifying the economic self-interest of health professionals they have ignored the altruistic, "intrinsic" motivators of professional service.[14] But social organizations can transform good motives to unintended and undesirable ends. It is this tendency that requires the close examination of the operation of systems of regulation. Systems which regulate individual practitioners do not alter or direct the larger profession; in fact, they probably work to promote the status quo. An example of the larger system overwhelming and reshaping good intent comes from the recent move to install consumers on regulatory boards. Consumers were included on these boards as a way of getting consumer input on the regulation of health occupations. Analysis of their input shows that in fact consumers are often intimidated by the expertise and authority of provider members of the boards.[15]

It remains for midwives and the host of emerging medical occupations to match their innovations in care with innovations in regulation. The challenge is to create a system that allows for independence, ensures competency, and does not exclude consumers.

Various alternative models of regulation have been suggested. These include such things as title licensure, the use of contracts, institutional licensure and credentialing, requiring disclosure of performance, and the regulation of procedures, not occupations.[16] A study commissioned by

the California Board of Medical Quality Assurance suggested an interesting modification of the state's medical practice act along the lines of this last suggestion. It would reserve licensed status for those practitioners engaging in any of five high-risk activities: prescribing medication, surgery, diagnosing, radiation, and the use of invasive instrumentation. All other health workers would simply be required to register with the state.[17]

The popularity of new medical occupations provides the opportunity to test these models. The lessons learned can be applied in reforming the regulation of other health personnel in an effort to liberate health care from the harmful effects of professional capture. Alternative models of licensure will allow adaption to the changed situation of health care where new sources of control, including malpractice insurers and health care corporations, are superseding the traditional legislative means of regulating health care personnel.

REFERENCES

1. Cuddihy NR: On nurse-midwifery legislation. J Nurse-Midwifery 1984; 29:55–56.
2. *Commonwealth v. Porn*, 196 Mass. 326, 326, 82 N.E. 31 (1907).
3. *Banti v. State*, 289 S.W. 2d 244 (1956).
4. *Bowland v. Municipal Court*, 18 Cal. 3d 479 (1976).
5. *Leggett v. Tennessee Bd. of Nursing*, 612 S.W. 2d 476 (Tenn. 1981).
6. *Leigh v. Bd. of Registration in Nursing*, 481 N.E. 2d 1347 (Mass. 1985).
7. DeVries R: Regulating Birth: Midwives, Medicine, and the Law. Philadelphia: Temple University Press, 1985; 119–138.
8. Evenson D: Midwives: survival of an ancient profession. Womens' Rights Law Reporter 1982; 7:313–330.
9. Yates SA: Professional Liability Insurance for Nurse-midwives. Washington, DC: American College of Nurse-Midwives, 1985.
10. National Center for Health Statistics, SJ Ventura: Births of Hispanic Parentage, 1982. Monthly Vital Statistics Report 1985; 34, 4(supp).
11. Jaschik S: States to get model legislation on physical therapy licensing. Chronicle of Higher Education, Sept. 1985; 25.
12. Hood G: At issue: titling and licensure. Am J Nurs May 1985; 592–594.
13. The Nation's Health: Fraction of dangerous doctors disciplined. The Nation's Health, October–November 1985; 10.
14. Freidson E: Foreword. *In:* Gritzer G, Arluke A, The Making of Rehabilitation. Berkeley: University of California Press, 1985.
15. Hanson B: An ethnography of power relations. *In:* Roth J (ed): Research in the Sociology of Health Care, Vol. 1. Greenwich, CT: JAI Press, 1980.
16. See Gross SJ: Of Foxes and Hen Houses: Licensing and the Health Professions. Westport, CT: Quorum Books, 1984; 160–185.
17. California Board of Medical Quality Assurance: Proposal for the revision of section 2052 of the Medical Practice Act, 1982.

New Name for AHA Human Resources Society

Members of the American Hospital Association's Society for Hospital Personnel Administration (ASHPA) have voted by an overwhelming 94 per cent margin to change the society's name to the American Society for Healthcare Human Resources Administration (ASHHRA). The name change, the first in the society's 22-year history, became effective July 16 at the annual business meeting held during the society's Annual Meeting and Conference in Denver.

The new name reflects major changes which have taken place in the hospital industry within the past 10 years, particularly hospital restructuring and diversification into alternative delivery systems. At the same time these changes were taking place, the scope of human resources management in hospitals was broadening. In addition to traditional responsibilities for compensation and benefits administration, employment and recruitment, and employee and labor relations, today's human resources professional is often responsible for strategic planning, human resources information systems, volunteer services, management engineering, organizational development, and employee health, education and training. The highest-level human resources professional in many health care institutions has become part of the organization's executive management team, often carrying the title of vice president or assistant administrator.

ASHHRA, with 2,500 members, is one of 16 personal membership socieities affiliated with the American Hospital Association. The AHA, a not-for-profit association, serves as a national advocate for hospitals, provides education and information for its members, and informs the public about hospital and health care issues.

For more information about the American Society for Healthcare Human Resources Administration, and its affiliated chapters, contact Brandon Melton, Director, ASHHRA, 840 North Lake Shore Drive, Chicago, IL 60611, 312/280–6111.