10

Lessons from Medicine's Experiment with Nurse Practitioners and Physician Assistants

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The idea of independent legal paraprofessionals offering legal services in currently underserved areas at more affordable price points is gaining traction across the country. Over the past several years, an increasing number of states have been studying and moving forward with licensing paraprofessionals, including Arizona, Utah, Oregon, Minnesota, Colorado, and New Hampshire.[1] When arguing in favor of the licensure of nonlawyer legal advocates, reform proponents almost inevitably draw analogies to nurse practitioners (NPs) and physician assistants (PAs).[2] But many law reformers know relatively little about these mid-level health care providers or whether it is *actually* true that these providers furnish accessible and affordable high-quality care. This chapter addresses this knowledge gap and, in so doing, looks for lessons that the experience of mid-level health care providers offers for access-to-justice reforms.

In both law and medicine, the most important question raised by the creation of middle tiers of providers is whether mid-level providers can provide high-quality services despite their shorter training periods. An important subsidiary question is whether, by virtue of their less expensive training, they increase the access of underserved populations to care. This chapter looks for clues in the significant body of empirical evidence about their work.

This chapter also identifies important differences between the medical and legal marketplaces that may determine whether nonlawyer advocates can duplicate the successes of NPs. The most important differences are the widespread presence of insurance in medicine and the chronic shortage of primary care physicians.

[1] Nora Freeman Engstrom & James Stone, *Auto Clubs and the Lost Origins of the Access-to-Justice Crisis*, 134 YALE L.J. 123 (Oct. 2024) (compiling citations).

[2] *See, for example*, Nora Freeman Engstrom, *Effective Deregulation: A Look under the Hood of State Civil Courts*, JOTWELL (Oct. 31, 2022), https://legalpro.jotwell.com/effective-deregulation-a-look-under-the-hood-of-state-civil-courts/ (last accessed Feb. 3, 2025); Stephen Daniels & James Bowers, *Alternative Legal Professionals and Access to Justice: Failure, Success, and the Evolving Influence of the Washington State LLLT Program (The Genie Is Out of the Bottle)*, 71 DEPAUL L. REV. 227, 240–41 (2022).

In addition, medicine has a long history of accommodating a wide variety of medical professions of varying scope and stature, ranging from ophthalmologists to audiologists, and from nurses to X-ray techs. In the field of law, by contrast, attorneys have largely reserved the entire field to themselves. As a result, the arrival of nonlawyer advocates has the potential to be much more disruptive and existentially disquieting than the emergence of NPs was to physicians.

The remainder of this chapter unfolds as follows. Section 10.1 begins by exploring how modern medicine has accommodated multiple categories of nonphysician health care providers for over a century. It then traces the origins of the NP and PA professions and the reactions of physicians. Section 10.2 describes the impact that NPs and PAs have had on patient care, focusing on the quality of services they provide and their impact on access to care for both rural and uninsured patients. Section 10.3 then explores the lessons that this medical story offers for improving access to legal services.

10.1 THE RISE OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

At their inception in the 1960s, NPs were a novel hybrid of nurse and physician. Unlike nurses, they had the authority to order tests, diagnose conditions, and select treatments, albeit under the supervision of a physician. That authority crossed a boundary that physicians had previously reserved for themselves. This sharing of core physician powers made NPs a naturally attractive analogy for law reformers seeking to create a new category of mid-level legal professionals with some of the powers previously held exclusively by attorneys, such as negotiating a settlement or appearing before a tribunal. These reformers could equally well have relied on an analogy to PAs, whose scope of practice largely mirrors that of NPs.

In the field of law, however, proposals to delegate this kind of authority to mid-level practitioners have generated far more opposition from the organized bar than medical reformers faced when creating the NP and PA professions in the mid-1960s. Several aspects of the health care environment in the twentieth century may help explain medicine's warmer reception.

10.1.1 *The Long History of Multiple Health Care Professions*

In medicine, limited license medical specialists have long shared the health care field with physicians. These limited license professionals range from doctorate-level nonphysicians who have full authority to treat a limited range of maladies free from the supervision of a physician, like dentists and optometrists, to mid-level providers who can care for virtually all patients but can only provide a limited set of services, like registered and practical nurses. To handle even more discrete tasks, medicine has also created dozens of more limited allied health professions, like radiology techs

and phlebotomists. This division of labor is a fundamental aspect of the delivery of modern medicine. Without it, health care would be much more expensive and much less accessible.

Medicine's division of labor began over a century ago. At that time, the parameters of acceptable "medical" practice were not well defined. In the late nineteenth and early twentieth centuries, allopathic physicians (MDs) were fighting and defeating homeopaths, naturopaths, and, for a time, osteopaths for control over the practice of medicine.[3] All three forms of alternative medicine arose as a reaction against traditional medicine, which at that time was often harsh and sometimes harmful. The first, homeopathy, was created in the late eighteenth century around two key precepts: First, the Law of Similars dictated that patients be treated with remedies that would generate symptoms similar to those being experienced by the patient ("like cures like") and, second, the Law of Infinitesimals called for prescriptions to be very, very highly diluted.[4] Naturopathy also arose in the 1890s. It sought to prevent and cure disease by stimulating the body's natural healing abilities. One of the founders defined it as a broad discipline that included practices like hydrotherapy, herbal medicine, homeopathy, and a healthy diet.[5] To a large extent, naturopaths opposed surgery and prescription drugs.[6] Early osteopathy, for its part, was created in the 1890s around the belief that diagnosing and treating the musculoskeletal system could successfully treat most illnesses, including those involving internal organs and the brain.[7]

Allopathic physicians argued that all three approaches were unproven, in some cases scientifically implausible, and likely to keep patients away from conventional care that could help them.[8] As a result, physicians successfully pushed homeopathy and naturopathy to the margins of the field. In the second half of the twentieth century, they abandoned their objections to osteopathy after it embraced evidence-based medicine.

While this fight was taking place in hospitals and state legislatures, other medical professions were cementing their own place in the health care marketplace. For example, nursing, optometry, and pharmacy all had their first state practice acts in place by 1903.[9] Podiatrists (foot doctors) began organizing as a profession in the early

[3] Ruth Horowitz, In the Public Interest: Medical Licensing and the Disciplinary Process (2012).

[4] *See* Viola Maria Schulz et al., *Systematic Review of Conceptual Criticisms of Homeopathy*, 9(11) Heliyon E21287, 1-2 (2023).

[5] *See Unsolved: Naturopathy*, HandWiki (Jan. 24, 2024), https://handwiki.org/wiki/Unsolved:Naturopathy (last accessed Feb. 3, 2025).

[6] *See id.*

[7] *See* Abigail Zuger, *Scorned No More, Osteopathy Is on the Rise*, N.Y. Times (Feb. 7, 1998), at F1 (reviewing the changes in training and the increased receptiveness of physicians).

[8] *See, for example*, *Id.*

[9] *See* Harold L. Wilensky, *The Professionalism of Everyone?* 70 Am. J. Socio. 137, 1423 tbl. 1 (1964). All states had optometry practice acts by 1921. *The History of the American Optometric Assn.*, Am. Optometric Ass'n, https://www.aoa.org/archives/ (last accessed Aug. 4, 2023);

1900s, and by 1923 at least twenty-three states had enacted practice acts that granted them the right to diagnose and treat diseases of the foot without physician supervision, thus eliminating the risk of prosecution for the unauthorized practice of medicine.[10]

Physical therapists (PTs) and occupational therapists gained credibility during World War I when they were given status as "reconstruction aides" for badly injured soldiers.[11] The arrival of polio cemented their roles. All these professions had limited licenses that overlapped with the general, unrestricted health care license of physicians.

Physicians did not campaign against nurses and PTs as they had against naturopaths and homeopaths, perhaps because nurses and PTs worked under the direction of a physician. Optometrists were not so lucky. They dueled with physicians in state courts and legislatures for decades over their right to exist as a separate profession (was refraction "the practice of medicine"?) and then over the scope of their practice.[12] Those battles continued to rage throughout the twentieth century as the two professions battled over optometrists' freedom to use new innovations such as diagnostic eye drops and therapeutic lasers.[13]

Following World War II, new technologies quickly expanded the use of laboratory tests and diagnostic imaging. For each of these tasks, new staff were needed. Each staffing specialty eventually coalesced into a new limited license profession. Many fell into the category that universities now call the "allied health professions." They include laboratory techs and techs for every major kind of imaging device, including diagnostic radiography, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, and ultrasound.[14] These licenses can be quite

Diane Benefiel, *The Story of Nurse Licensure*, 36 Nurse Educ. 16, 16 (2011) ("By 1923, all 48 states had passed some form of nursing licensure legislation. . . . In 1938, New York passed the first mandatory nurse licensure legislation.")

[10] *See* Louis T. Bogy, *Podiatry*, Tex. Hist. Soc'y (1995), https://www.tshaonline.org/handbook/entries/podiatry (last accessed Feb. 3, 2025) (number of practice acts); *Historical Highlights of APMA*, apma, https://www.apma.org/about-apma/governance/who-we-are/historical-highlights-of-apma/ (last accessed Feb. 3, 2025). Podiatry is "the medical care and treatment of the human foot." *Podiatry*, Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/podiatry#:~:text=Kids%20Definition-,podiatry,treatment%20of%20the%20human%20foot (last accessed Aug. 4, 2023).

[11] *See A Brief History of Occupational Therapy*, my OT SPOT (Sept. 6, 2019, last updated May 13, 2023), https://www.myotspot.com/tag/ot-history/ (last accessed Aug. 2, 2023); *History of the Occupational Therapy Profession*, Prince Edward I. C. of Occupational Therapists, https://www.peiot.org/pei-ot-history (last accessed Feb. 3, 2025).

[12] *See* Bill Kekevian, *Legalizing Optometry: A Behind-The-Scenes Look at the People, the Moments and the Legislation That Made the Profession What It Is Today*, Rev. of Optometry (2016), https://www.reviewofoptometry.com/article/legalizing-optometry#:~:text=Optometry's%20first%20licensure%20law%2C%20passed,and%20as%20recently%20as%202008 (last accessed Feb. 3, 2025).

[13] *See id.*

[14] *See* Christine Harris, *Evolution of a Profession: A Rad-Tech's Reflections*, 50 Applied Radiology 28 (2021), https://appliedradiology.com/articles/evolution-of-a-profession-a-rad-

specialized; Arizona, for instance, licenses nine different kinds of radiologic technologists.[15]

Emergency Medical Technicians (EMTs) and paramedics have a different origin story. Their professions arose in response to a 1966 national report on auto accident injuries. The report revealed that vehicle accidents in 1965 killed more Americans than were lost in the entire Korean War.[16] A seriously injured accident victim had a better chance of survival in a combat zone than on the side of the road. The report called for the standardization of training for emergency response personnel. Soon after, Congress passed the National Highway Traffic Safety Act of 1966, which standardized emergency medical service training and promoted state involvement.[17]

Today, the number of limited license health care professions is vast. California now licenses acupuncturists, audiologists, chiropractors, clinical social workers, contact lens dispensers/spectacle lens dispensers, dental assistants, dental hygienists, dentists, educational psychologists, hearing aid dispensers, marriage and family therapists, midwives, naturopathic doctors, NPs, occupational therapists, opticians, optometrists, osteopathic physicians, pharmacists, pharmacy technicians, PTs, PAs, physicians, podiatric medical doctors, professional clinical counselors, psychiatric technicians, psychiatrists, psychologists, registered nurses, respiratory therapists, speech-language pathologists, and vocational nurses.[18] At any given time, one or more will be wrestling with physicians over the boundaries of their permitted scope of practice. But on the whole, the many health care professions have learned to accommodate one another.

In short, physicians have shared the field of medicine with other limited license professionals from the very earliest days of modern allopathic dominance. This sharing and specialization allow the delivery of higher-quality services in a more efficient manner. It delegates less complex and less remunerative tasks to less expensively trained providers, saving time for physicians to provide more

tech-s-reflections (last accessed Feb. 3, 2025). In 1970, four states had legislation and by 1995, thirty-three states did. *History of the American Society of Radiologic Technologists*, Am. Soc'y Radiologic Technologists, https://www.asrt.org/main/about-asrt/museum-and-archives/asrt-history (last accessed Aug. 4, 2023).

[15] *See Special Licensing*, Ariz. Dep't Health Serv., https://www.azdhs.gov/licensing/special/index.php#mrt-provider-info (last accessed Aug. 23, 2023).

[16] *See* Dennis Edgerly, *Birth of EMS: The History of the Paramedic*, 38(12) J. Emergency Med. Serv. 10 (2013), https://www.jems.com/administration-and-leadership/birth-ems-history-paramedic/ (last accessed Feb. 3, 2025); Joshua Bucher and Hashim Q. Zaidi, *A Brief History of Emergency Medical Services in the United States*, EMRA, https://www.emra.org/about-emra/history/ems-history (last accessed Aug. 4, 2023).

[17] *See* Bucher and Zaidi, *supra* note 16.

[18] *See Consumer's Guide to Healthcare Providers*, Cal. Dep't Human Affs. (Jan. 2014), https://www.dca.ca.gov/publications/healthcare_providers.shtml (last accessed Aug. 1, 2023).

complicated (and more highly remunerated) services. In medicine, the widespread sharing of duties from the top to the bottom has normalized it.

The story in law is markedly different. According to scholars Rebecca L. Sandefur and Matthew Burnett, "[b]y the middle of the 20th century, American lawyers had successfully captured most of the tasks of the practice of law, including negotiation and legal advice."[19] Since then lawyers have kept the territory securely to themselves. While several formal and informal exceptions exist,[20] they are only now emerging from the margins of the profession. In law, unlike medicine, their arrival constitutes an assault on normalcy.

10.1.2 *The Spread of Health Insurance, the Emergence of Physician Scarcity, and the Growth of NPs and PAs*

Two other historical factors were crucially important to the early acceptance of NPs and PAs. One was the emergence of widespread health insurance after World War II. The second was the shortage of primary care physicians that followed in its wake. NPs and PAs were viewed as part of the solution.

Both professions arose in the aftermath of World War II and the War on Poverty, the occurrence of both the events having changed medicine. During World War II, employers used health insurance coverage as a way to sidestep four years of wartime wage controls.[21] As a consequence, the percentage of the population with health insurance skyrocketed from 9 percent before World War II to nearly 70 percent by 1960.[22] Enrollment grew from 20,662,000 in 1940 to nearly 142,334,000 in 1950.[23] The pool of insured Americans grew again in 1965 when President Lydon Johnson signed legislation creating Medicare and Medicaid. Nineteen million Americans signed up for Medicare in the first year alone.[24]

Yet, just as the ranks of the insured were swelling, the number of new primary care physicians was dropping; physicians were moving away from primary care

[19] *See* Chapter 17 in this volume.

[20] *Id.* at 7 (noting that nonlawyers are permitted to serve clients before several federal administrative agencies); Engstrom, *supra* note 2 (describing lay advocates who assist clients in cities across the country in matters ranging from domestic violence to child welfare).

[21] Justin Barr & Scott H. Podolsky, *A National Medical Response to Crisis – The Legacy of World War II*, 383 N. Engl. J. Med. 613 (2020); George B. Moseley III, *The U.S. Health Care Non-System, 1908–2008*, 10 AMA J. Ethics 324, 325–26 (2008).

[22] Alex Blumberg & Adam Davidson, *Accidents of History Created U.S. Health System*, All Things Considered (Oct. 22, 2009), https://www.npr.org/2009/10/22/114045132/accidents-of-history-created-u-s-health-system (last accessed Aug. 23, 2023).

[23] Melissa Thomasson, *Health Insurance in the United States*, EH.Net Encyclopedia (Apr. 18, 2003), www.eh.net/encyclopedia/article/thomasson.insurance.health.us (last accessed Aug. 23, 2023).

[24] *See A Brief History of Medicare in America*, Medicare Res., https://www.medicareresources.org/basic-medicare-information/brief-history-of-medicare/ (last accessed Aug. 4, 2023).

toward specialties.[25] As a result, America had far too few primary care providers to serve this growing pool of insurance-card-carrying patients.[26]

Facing this crisis in capacity, some individual physicians began training staff to provide routine care and office procedures.[27] Delegation of routine care to nurses was also expanding. To finesse the unauthorized practice of medicine issues, nursing, physician, and hospital associations periodically published joint statements supporting this practice.[28] But the arrangement was unstable. Then, the NP and PA professions were born.

The history of NPs begins in 1965 with the efforts of Loretta Ford, a former public health nurse and a professor of nursing. She teamed up with Henry Silver, a pediatrician, to create a post-registered nurse (RN) curriculum at the University of Colorado for advanced training in pediatric care. Motivating Ford was her awareness that rural public health nurses often visited new mothers and newborns who needed services that were outside the scope of their nursing licensure, such as the diagnosis and treatment of an infection. Yet, no rural physicians were available to legally provide these services.[29] Ford believed that nurses could fill that need if provided with specialized training. In hindsight, her quest strongly resembles the desire of today's law reformers to expand and legalize the help that nonlawyer community advocates can provide to clients who would otherwise have no legal assistance at all.

To some extent, Ford was building on past precedent. In 1925, Congress created the Frontier Nursing Service, which allowed trained nurses to serve as midwives.[30] Then in 1930, the Federal Bureau of Prisons deployed former military corpsmen to provide health care in prisons.[31] California did the same in 1949.[32] And in the 1940s, Alaska started training community health workers to serve in remote areas.[33] We see a similar phenomenon in law today as nonlawyer advocates are both formally and informally expanding their roles in several niches like domestic violence proceedings.[34]

From the outset, NPs had a substantially wider scope of practice than that of registered nurses. The licensing laws allowed NPs, unlike nurses, *to diagnose and*

[25] *See* Barr & Podolsky, *supra* note 21 ("World War II also fundamentally transformed health care provision nationwide. By rewarding physicians' board certification with rank and pay, the military catalyzed medical specialization in post-war America.").

[26] *See* Reginald D. Carter, *Exploring Opportunities and Challenges*, 7, 11, *in* Physician Assistants as Social Innovators in Healthcare (2022).

[27] *Id.* at 12.

[28] *See* Carter, *supra* note 26, at 14.

[29] She felt that the medical profession should solve the shortage of primary care physicians itself. *See Loretta Ford on the Evolution of the NP Role*, YouTube (uploaded May 2, 2016), https://www.youtube.com/watch?v=2pHbCw_HS-8 (last accessed Apr. 11, 2023).

[30] *See* Carter, *supra* note 26, at 12.

[31] *Id.*

[32] *Id.*

[33] *Id.*

[34] *See* Engstrom, *supra* note 2.

treat medical conditions in their area of training under the supervision of a physician. With physician oversight, they could admit patients, order imaging or lab tests, and later, write prescriptions.

At the same time, NPs were intended to complement and collaborate with physicians, not replace them.[35] Ford was careful to use wording that would not anger physicians.[36] Nearly all NPs were female, like the RN pool from which they were drawn, and nearly all MDs were male. Although many nursing schools did not welcome the new hybrid, they did not stand in the way of NP practice acts.[37]

The first PA program also started in 1965. Its student body consisted of four medics returning from the Vietnam War. Eugene A. Stead, an MD and the program's creator, felt that the rapid training programs taken by these medics during the war could be adapted to train a cadre of quickly, but highly, trained medical assistants to help remedy the shortage of physicians. He used funding from the National Heart Institute to establish the first program at Duke in 1965.[38]

Although both professions require two years of additional coursework, their entry path and training are different. NP programs require that the applicant be an RN with some practice experience.[39] Students take two years of classwork and clinical training in a specialty area, like pediatrics. By contrast, most PA programs accept any bachelor's degree.[40] Like medical schools, however, they have substantial science course prerequisites and require the taking of a competitive examination.[41] Some programs also require prior experience in health care such as being a paramedic or medical assistant.[42] PAs then take a two-year course of classes and clinical work that is essentially a condensed version of medical school.[43] They do not specialize during this basic training. And because there is no medical residency, they can go directly to work after the two-year program, cutting six years off the training of an MD.

[35] *See* A. Keeling, *Historical Perspectives on an Expanded Role for Nursing*, 20 OJIN: Online J. of Issues in Nursing 2 (2015) (recalling that Ford wanted NPs to work collaboratively with MDs initially to address common childhood health problems during well baby checks).

[36] *See Loretta Ford Documentary*, YouTube (uploaded Nov. 5, 2019), https://www.youtube.com/watch?v=-Shw9wFswOI (last accessed Jan. 7, 2023).

[37] *See* Elizabeth Landau, *Nurse Practitioners Were "Lone Rangers," Founder Says*, CNN (Oct. 1, 2011), https://www.cnn.com/2011/09/30/health/living-well/loretta-ford-nurse-practitioner/index.html (last accessed Feb. 3, 2025).

[38] *See* Roderick S. Hooker & Reginald D. Carter, *From Concept to Reality* 19, 23–24, *in* Physician Assistants as Social Innovators in Healthcare (2022).

[39] *See Nurse Practitioner Career Overview*, NurseJournal.org (updated Mar. 3, 2023), https://nursejournal.org/nurse-practitioner/ (last accessed Aug. 24, 2023) (stating that most programs require two years of RN experience).

[40] *See Become a PA*, Am. Ass'n of Physicians' Assistants, https://www.aapa.org/career-central/become-a-pa/ (listing common classes) (last accessed Aug. 24, 2023).

[41] *Id.*

[42] *See* Bureau of Lab. Stat., U.S. Dep't of Labor, *Physician Assistants*, Occupational Outlook Handbook (last modified Aug. 29, 2024), https://www.bls.gov/ooh/healthcare/physician-assistants.htm (last accessed Apr. 12, 2023).

[43] *See* Hooker & Carter, *supra* note 38, at 23.

After graduation, PAs, like NPs, practice under the direction of a supervising physician. But unlike NPs, the supervising physician determines the PA's legal scope of practice.[44] If their supervising physician permits, they too can order tests, diagnose illnesses, and select treatments. In most cases, their practice is essentially identical to that of NPs, and, in clinical practice, PAs commonly work side-by-side with NPs doing identical work.[45]

Both fields are growing more rapidly than physicians. According to the Bureau of Labor Statistics, the growth rate between 2021 and 2031 is expected to be 3% for physicians,[46] 28% for PAs,[47] and 40% for NPs.[48] Both NPs and PAs are regularly ranked at or near the top of the *U.S. News and World Report* rankings of the best jobs in health care and the best jobs overall.[49] In 2021, NPs averaged $120,680 annually,[50] and PAs averaged $121,530.[51]

In the early years, neither NPs nor PAs faced opposition from organized medicine. Several factors may explain this acquiescence. First, as noted above, health care had a long tradition of utilizing trained and licensed mid-level providers to assist physicians. Second, physicians benefitted from the arrival of the new mid-level professionals (unlike the professionalization of optometry). They got better-trained assistants to whom they could delegate more complex tasks while still billing all the services in their own name. The new staff also freed them to undertake more lucrative procedures with their own time. Third, the new professionals were clearly subordinate to the physicians who supervised and directed their work. Physician primacy was not challenged. No patients were lost. Fourth, the health care marketplace had too few physicians, especially in primary care. Help was needed. Fifth, the

[44] *See id.* at 36.

[45] *See* Erin Sarzynski & Henry Barry, *Current Evidence and Controversies: Advanced Practice Providers in Healthcare*, 25 Am. J. Managed Care 366, 366 (2019) ("Despite differences in training and licensure, APPs have considerable overlap in their scope of practice."; there were "few differences in their roles and perception of care by administrators."); Karen Donelan et al., *Perspectives of Physicians and Nurse Practitioners on Primary Care Practice*, 368 N. Engl. J. Med. 1898, 1903 (2013) ("Both physicians and NPs agree that they perform largely the same services.").

[46] *See* Bureau of Lab. Stat., U.S. Dep't of Labor, *Physicians and Surgeons*, Occupational Outlook Handbook (last modified Aug. 29, 2024), https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm (last accessed Aug. 23, 2023).

[47] Bureau of Lab. Stat., U.S. Dep't of Labor, *supra* note 42.

[48] Bureau of Lab. Stat., U.S. Dep't of Labor, *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners*, Occupational Outlook Handbook (last modified Aug. 29, 2024), https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm (last accessed Apr. 12, 2023).

[49] *See, for example*, *Nurse Practitioner Role Named "Best Job That Helps People,"* Am. Ass'n of Nurse Prac. (Mar. 13, 2023), https://www.aanp.org/news-feed/nurse-practitioner-role-named-best-job-that-helps-people (last accessed Feb. 3, 2025); *Physician Assistant*, USNews, https://money.usnews.com/careers/best-jobs/physician-assistant (last accessed Aug. 23, 2023) ("#2 in Best Health Care Jobs; #4 in 100 Best Jobs.").

[50] Bureau of Lab. Stat., U.S. Dep't of Labor, *supra* note 48.

[51] Bureau of Lab. Stat., U.S. Dep't of Labor, *supra* note 48.

field had an ample pool of insurance funds from which to pay the new mid-level providers.

10.1.3 *The Political Winds Changed When NPs and PAs Sought Independence from Physician Direction*

The honeymoon with physicians did not last. Today, NPs and PAs want full independence from physician oversight.[52] Faced with the prospect of NP and PA independence and the accompanying threat to physician income, organized medicine is fiercely fighting these state legislative proposals.

Of course, the objections expressed publicly by physicians do not focus on the protection of their turf. Instead, three other arguments are commonly voiced. The first is that quality will be impaired if NPs and PAs are given too much independence. Physicians don't believe that mid-level providers deliver the same quality of care that physicians do, especially in complex cases.[53] Second, physicians insist that mid-level providers are no more likely than physicians to serve low-income and underserved patients.[54] These two contentions will be familiar to reformers who are trying to authorize mid-level legal practitioners. Third, physicians contend that NPs will overuse medical procedures like imaging and lab tests to protect against mistakes caused by their weaker education and training, driving up health care costs.[55]

The issue of quality is the most important of these objections. Here, NPs have benefited from a large and growing body of favorable outcomes data refuting physicians' claims. The strong evidence that NPs and PAs provide high-quality care has enabled NPs to enlist the help of important allies like the American Enterprise

[52] *Utah's New Law Will Improve Patients' Health Care Access*, Am. Ass'n of Nurse Prac. (Mar. 16, 2023), https://www.prnewswire.com/news-releases/utahs-new-law-will-improve-patients-health-care-access-301774618.html#:~:text=Spencer%20Cox%20and%20the%20Utah,from%20nurse%20practitioners%20(NPs).&text=Utah%20is%20now%20the%2027th,to%20adopt%20Full%20Practice%20Authority (last accessed Aug. 23, 2023).

[53] *See, for example*, Donelan et al., *supra* note 45, at 1902. In a survey, two-thirds of physicians believed that doctors provide higher-quality examinations and consultations. *Id.* Only 18 percent of physicians felt NPs should lead medical homes, compared to 82 percent of NPs. Only 4 percent of physicians felt NPs should be paid equally for providing the same service, while 64 percent of NPs disagreed. *Id.*

[54] *See Scope of Practice: Key Tools & Resources*, Am. Med. Ass'n (Jan. 7, 2025), https://www.ama-assn.org/practice-management/scope-practice/scope-practice-key-tools-resources (last accessed Feb. 3, 2025) (stating that "[t]he AMA created over 4,500 geomaps to demonstrate that expanding scope does not equal expanding access to care").

[55] *See, for example*, *AMA Issue Brief: Expanding Nurse Practitioner Scope of Practice Leads to Increased Utilization of Health Care Resources*, Am. Med. Ass'n (2022), https://amascopeofpractice.org/wp-content/uploads/2023/01/Issue-Brief-2023-NP-Increased-Utilization-of-Health-Care-Resources-FINAL.pdf; *AAFP Warns of Dangers in Bill to Expand NPPs' Practice Scope*, Am. Ass'n of Family Physicians, https://www.aafp.org/news/government-medicine/npp-scope-letter.html (last accessed Jan. 30, 2024).

Institute,[56] the Brookings Institute,[57] the Institute of Medicine,[58] the Robert Wood Johnson Foundation,[59] the American Association of Retired Persons (AARP),[60] the Federal Trade Commission (FTC),[61] and the National Governors Association.[62] NPs have even enlisted some of the physician lobby's usual allies, like health insurers, hospital associations, and chambers of commerce. Their supporters see the removal of NP scope-of-practice restrictions as a way to bring down costs and make access to health care more equitable.[63] To this end, the Robert Wood Johnson Foundation allied with the AARP to launch *The Future of Nursing: Campaign for Action*, a nationwide initiative for state law reform.[64]

State by state, the fundraising and the recruitment of consumer groups by the National Association of Nurse Practitioners has been very sophisticated.[65] The NP coalition in New Jersey, for example, included AARP New Jersey, the Chamber of Commerce, the Horizon Foundation of New Jersey (Blue Cross Blue Shield's corporate foundation in New Jersey), and the New Jersey Hospital Association.[66] In Texas, NPs enlisted individual nursing organizations, hospitals, health care systems, businesses, and educational institutions, along with the Texas Association of Business and the Texas Hospital Association.[67]

This combination of favorable outcomes, important allies, and polished campaigning convinced lawmakers in twenty-seven states to enact Full Practice Authority legislation for NPs.[68] These laws empower NPs to diagnose conditions

[56] Peter Buerhaus, Nurse Practitioners: A Solution to America's Primary Care Crisis (2018).

[57] E. Kathleen Adams & Sara Markowitz, Improving Efficiency in the Health-Care System: Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants (2010).

[58] Inst. Medicine, The Future of Nursing (2010) [hereinafter, Future of Nursing 2010].

[59] *Future of Nursing: Campaign for Action*, Robert Wood Johnson Found., https://beta.rwjf.org/en/grants/grantee-stories/programs/future-of-nursing–campaign-for-action.html (last accessed Aug. 23, 2023).

[60] *Campaign for Action*, AARP, https://campaignforaction.org/ (last accessed Aug. 25, 2023).

[61] *See* Daniel J. Gilman & Tara Isa Koslov, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*, FTC (Mar. 2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf (last accessed Feb. 24, 2025).

[62] Nat'l Governors Ass'n, The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care (2012).

[63] *See* Inst. of Medicine, The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity 7, 86 (2021) [hereinafter, Future of Nursing 2020–2030].

[64] *See supra* notes 51 and 52.

[65] *See* Stephen Isaacs & Paul Jellinek, Accept No Substitute: A Report on Scope of Practice 21–22 (2012).

[66] *Id.* at 23.

[67] *Id.*

[68] *Utah's New Law*, *supra* note 52.

and to order and implement treatments *without the need for a collaborative relationship with a physician*.[69] PAs are now working to enact similar legislation.

But physician groups have raised their game considerably since the first NP full-practice laws were passed. In the past few years, they have reached out more vigorously to physicians, residents, and medical students in each state where NP or PA scope-of-practice bills have been introduced. The American Medical Association (AMA) has prepared members-only talking points and posted them on its web page.[70] State by state, the AMA is helping local medical societies fashion a strong response when scope-of-practice reform bills are introduced.[71] Going forward, both NPs and PAs will face stiffer opposition.[72]

10.1.4 *Reviewing the Story*

In the 1960s, NPs and PAs were accepted into medicine without organized resistance. In hindsight, this is surprising. Each profession was permitted, under supervision, to diagnose and treat patients. Physicians could easily have perceived the delegation of their core medical powers to be an unacceptable intrusion into the central work of physicians. But they did not. The explanations for this peaceful entry may provide useful clues for law reformers. So, too, will the very different reaction that physicians had when NPs later sought freedom from physician oversight.

When the first NP and PA programs were created, the appearance of new mid-level health care providers was a routine occurrence. No existential norms were threatened. More importantly, physicians benefited financially from the arrival of these highly trained assistants. At the same time, the new professionals did not challenge physician primacy. Crucially, the new mid-level professionals would not be taking patients away from physicians. With a chronic shortage of primary care providers, there were patients enough to go around. Lastly, the practice of medicine was blessed with an ample pool of insurance funds from which to pay the new mid-level providers without taking a slice of the pie from physicians.

Law reformers can duplicate some of these favorable conditions with careful crafting of boundaries, as discussed further in Section 10.3. But the absence of

[69] *See, for example*, N.H. Stat. 326-B:11 (2024); N.D. Admin. Code 54-05-03.1-03.2 (2023); *Issues at a Glance: Full Practice Authority*, Am. Ass'n of Nurse Prac. (revised Aug. 2024), https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief (last accessed Jan. 28, 2024); Nat. Council of St. Bds of Nursing, Model Act (2021). NPs are supervised by the state board of nursing rather than the board of medicine. *Id.* The AANP now strongly disfavors the term "midlevel provider." Am. Assn. Nurse Prac., *Id.*

[70] *See Scope of Practice*, *supra* note 54.

[71] *Id.*

[72] The AMA says it has recently defeated both NPs and PAs in half a dozen states. *See Advocacy in Action: Fighting Scope Creep*, Am. Med. Ass'n (updated Aug. 14, 2023), https://www.ama-assn.org/practice-management/scope-practice/advocacy-action-fighting-scope-creep (last accessed Aug. 24, 2023).

insurance, the lack of a tradition of sharing the legal ecosystem, and the oversupply of JDs are three environmental differences that pose unique challenges for law reformers. They, too, are discussed in Section 10.3.

NPs lost the support of physicians when they sought independence from physician oversight. Freed from physician oversight, NPs could set up their own practices, compete for patients, potentially lower prices, and acquire a status akin to a physician, at the top of the medical hierarchy. As NPs sought this greater independence and prestige, physicians began to view NPs as a financial threat, rather than a financial windfall. This new perspective caused a shift in physicians' attitudes toward NPs – a shift that also offers lessons for law reform.

10.2 THE OUTCOMES RESEARCH: NPS AND PAS DELIVER HIGH-QUALITY CARE

As noted above, NPs offer a naturally attractive analogy for law reformers working to create a category of licensed, mid-level legal professionals. This section examines the impact that NPs have had on patient care, focusing especially on the quality of services rendered and the impact on access to care for both insured and uninsured patients.

In the six decades since Loretta Ford created the first NP program, dozens of studies have investigated the care provided by NPs and, to a lesser extent, PAs. Although the studies all have limitations, they consistently find that both professions deliver high-quality care. Recent research also suggests that NPs modestly increase access to care. The positive findings about quality of care in particular have helped NPs and PAs recruit a wide variety of important allies in their current quest for full independence.

10.2.1 *Quality of Care*

The quality of care provided by NPs has been studied much more than care provided by PAs. The studies of NP quality of care use data from a variety of practice settings and contexts, including primary care, nursing homes, Veterans hospitals, Medicare recipients, and emergency departments, and they employ many methodological and statistical approaches. Yet, the findings have been surprisingly consistent and positive: The number of studies finding that NP care is equal to or better than the care provided by physicians vastly outnumber the unfavorable ones. As a result, the major literature reviews have consistently concluded that, on balance, NPs provide care that is equal to or better than care provided by physicians, though reservations are sometimes expressed about the most complex cases.[73]

[73] *See, for example*, Melanie Swan et al., *Quality of Primary Care by Advanced Practice Nurses: A Systematic Review*, 27 Int. J. Qual. H. Care 396, 396, 400 (2015) (RCTs find equal or better

These findings have been relied upon in several important public policy reports encouraging the growth of the NP supply and the expansion of their scope of practice, including reports from the Office of Technology Assessment,[74] the Institute of Medicine,[75] and the province of British Columbia.[76]

The only regular reservation is the desire for more research on complex cases.[77] However, the research on tough cases is growing. For example, an important 2019 review of the studies on acute and critical care by Ruth Kleinpell and her colleagues found evidence of improved patient outcomes when supervised NPs and PAs deliver care. The positive metrics included:[78]

1. Fewer complications
2. Less time on ventilation
3. More use of clinical practice guidelines
4. Improved laboratory test use
5. Increased palliative care consultations
6. Reduced length of hospital stay
7. Reduced readmissions
8. Improved discharge time
9. Longer ICU survival rates
10. Better patient care management

outcomes for physiologic measures, such as blood pressure and glucose outcomes, cholesterol); Brigitte Fong Yeong Woo et al., *The Impact of the Advanced Practice Nursing Role on Quality of Care, Clinical Outcomes, Patient Satisfaction, and Cost in the Emergency and Critical Care Settings: A Systematic Review*, 15 Hum. Res. Health 63, 63 (2017) (reporting that "the involvement of nurses in advanced practice in emergency and critical care improves the length of stay, time to consultation/treatment, mortality, patient satisfaction, and cost savings"); Ruth Kleinpell et al., *Nurse Practitioners and Physician Assistants in Acute and Critical Care: A Concise Review of the Literature and Data 2008–18*, 47 Crit. Care Med. 1441, 1446 (2019) (reviewing studies of acute and critical care and finding equal or better outcomes).

[74] U.S. Congress, Off. Tech. Assessment, Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis 5 (1986) ("The weight of the evidence indicates that, within their areas of competence, NPs, PAs, and CNMs provide care whose quality is equivalent to that of care provided by physicians.").

[75] *See* Future of Nursing 2020–2030, *supra* note 63.

[76] *See* Sabrina T. Wong & Vicki Farrally, The Utilization of Nurse Practitioners and Physician Assistants: A Research Synthesis (2014). This comprehensive report was prepared on behalf of the Nursing Research Advisory Council to provide decisionmakers in British Columbia, Canada, with a comprehensive international review and synthesis of the research literature pertaining to nurse practitioners and physician assistants.

Examining fourteen systematic reviews between 1981 and 2011, it found consistent evidence that NPs and PAs "within their scope of practice," provide "equivalent quality of care compared to their physician counterparts and they are well-accepted by patients."

[77] *See*, *for example*, Sarzynski & Barry, *supra* note 45, at 367 (calling for more research on acute care and complex patients).

[78] *See* Kleinpell et al., *supra* note 73, at 1446.

The literature also has positive findings on many other metrics, including blood pressure, glucose outcomes, cholesterol,[79] C-sections,[80] mental-health-related mortality,[81] and mortality more generally.[82] A much smaller set of studies have yielded negative findings, often around drug prescribing.[83] In addition, patients often prefer the care provided by NPs, feeling that NPs offer a more holistic approach than physicians.[84] NPs score consistently higher on patient satisfaction.[85]

The least favorable review of NP care was published in 2019 by Erin Sarzynski and John Barry, both MDs. They concluded that the studies offer "mixed results."[86] On the one hand, NPs had positive findings on studies such as the retrospective study of twenty million community health center patients that found equal or better results for NPs on quality metrics like smoking cessation, depression treatment, statin therapy, physical exams, patient education, imaging, medication use, return visits, and referrals.[87] On the other hand, other studies found that MDs ordered fewer unnecessary antibiotics for acute infections[88] and made fewer specialist referrals for patients with diabetes.[89] In the end, the authors conceded that "[p]hysicians' arguments about quality are largely unfounded, at least for common health concerns."[90]

[79] *See* Swan et al., *supra* note 73, at 400.
[80] *See* Future of Nursing 2020–2030, *supra* note 63, at 81.
[81] *See id.* at 150.
[82] *See* Woo et al., *supra* note 73, at 63.
[83] *See*, *for example*, Michael I. Ellenbogen & Jodi B. Segal, *Differences in Opioid Prescribing among Generalist Physicians, Nurse Practitioners, and Physician Assistants*, 21 Pain Med. 76 (2020) (relatively high rates of opioid prescribing among NPs and PAs, especially at the upper margins); Evan L. Dvorin et al., *High Frequency of Systemic Corticosteroid Use for Acute Respiratory Tract Illnesses in Ambulatory Settings*, 178 JAMA Internal Med. 852 (2018) (more inappropriate obsolete steroid use for acute respiratory tract infections).
[84] *Id.*
[85] *See*, *for example*, Elena Kraus & James M. DuBois, *Knowing Your Limits: A Qualitative Study of Physician and Nurse Practitioner Perspectives on NP Independence in Primary Care*, 32 J. Gen. Internal Med. 284 (2017).
[86] *See* Sarzynski & Barry, *supra* note 45, at 367.
[87] That study is E. T. Kurtzman & B. S. Barnow, *A Comparison of Nurse Practitioners, Physician Assistants, and Primary Care Physicians' Patterns of Practice and Quality of Care in Health Centers*, 55 Med. Care 615 (2017).
[88] *See* Johanna E. Bellon et al., *Comparing Advanced Practice Providers and Physicians as Providers of E-Visits*, 21 Telemed. J. eHealth 1019 (2015).
[89] *See* Yong-Fang Kuo et al., *Diabetes Mellitus Care Provided by Nurse Practitioners vs Primary Care Physicians*, 63 J. Am. Geriatric Soc'y 1980 (2015); Danny R. Hughes et al., *A Comparison of Diagnostic Imaging Ordering Patterns between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits*, 175 JAMA Internal Med. 101 (2015).
[90] *See* Sarzynski & Barry, *supra* note 45, at 367. A more recent prepublication manuscript claims to have found that patients who saw NPs in VA emergency departments had more "preventable hospitalizations" within thirty days of their visit, but it used criteria from the Agency for Healthcare Research and Quality that may also be measuring the intervening care provided in the VA hospitals after admission and any outpatient care that the patients received in the thirty days after being seen in the VA ED. *See* David C. Chan Jr. & Yiqun Chen, *The*

Researchers have done much less research on PA outcomes. Most studies that include PAs have combined the outcomes of PAs and NPs and reached favorable results.[91] When analyzed separately, PA outcomes seem to be very similar to those of NPs.[92]

Two pairs of recent studies with large databases deserve individual mention. In the first set, Peter Buerhaus and his coauthors used a Medicare primary care database that they adjusted for patient severity and found that patients receiving primary care from NPs were less likely to have preventable hospital admissions, hospital readmissions within thirty days of being discharged, inappropriate emergency department visits, and low-value MRIs associated with low back pain.[93] Physicians, however, had more positive findings for the number of cancer screenings (such as mammography screenings for breast cancer and colonoscopies for colorectal cancer).[94] In a second study using the same data, the authors narrowed their inquiry to Medicare beneficiaries with a disability or a very low income and had virtually the same findings.[95]

The other set of studies looked at complex diabetes patients in the Veterans Affairs (VA) system and found that NP and PA team leaders achieved control equivalent to that of physicians for blood glucose, blood pressure, and cholesterol.[96] The second study examining the same data set determined that patients of the NPs and PA team leaders were less likely to be hospitalized or to have an emergency room (ER) visit due to an ambulatory care-sensitive condition, even after adjusting for differences in

Productivity of Professions: Evidence from the Emergency Department, Nat'l Bur. of Econ. Rsch. 9, 15 (June 2023), https://www.nber.org/system/files/working_papers/w30608/w30608.pdf (last accessed Feb. 24, 2025); *Prevention Quality Indicator Methods*, Agency for Healthcare Rsch. & Quality Indicators, https://qualityindicators.ahrq.gov/measures/pqi_resources (last accessed May 2, 2023).

[91] *See* Wong & Farrally, *supra* note 76 at 30, 34 (very favorable overall).

[92] *See*, *for example*, Sarzynski & Barry, *supra* note 45, at 367 ("Quality of care is similar among NPs, PAs, and physicians for routine patient presentations, but evidence is less robust for complex patients."); George L. Jackson et al., *Intermediate Diabetes Outcomes in Patients Managed by Physicians, Nurse Practitioners, or Physician Assistants: A Cohort Study*, 169 Ann. Intern. Med. 825, 825 (2018) (no difference); George Goldberg et al., *Physician's Extenders; Performance in Air Force Clinics*, 19 Med. Care 951, 951(1981) ("Physician's assistants performed at least as well as physicians on 25 out of 28 nonredundant process–of–care criteria; . . . In a comparison of physician's assistants with nurse practitioners, the two groups' performance was not significantly different.").

[93] *See* Buerhaus, *supra* note 56, at 484, 487.

[94] *Id.* The authors concluded that each profession had "different strengths." *Id.* at 484.

[95] *See* Catherine M. DesRoches et al., *The Quality of Primary Care Provided by Nurse Practitioners to Vulnerable Medicare Beneficiaries*, 65 Nursing Outlook 679, 686–87 (2017) (finding that NP patients had a lower risk of preventable hospitalizations and emergency department use, less low-value imaging for low back pain and, unlike the larger study, equal chronic disease management but were less likely to have eye screenings or cancer screenings).

[96] *See* Jackson et al., *supra* note 92, at 825.

patients' medical and social complexity.[97] In a third study, the authors extended their inquiry to less complex diabetes patients, finding that, here too, patients of NPs and PAs had fewer inpatient admissions and less emergency department use than patients of physicians.

The VA studies are especially useful because they minimize two of the most significant potential biases in this research. First, physician consultation is minimal in the VA system.[98] Second, "incident to" billing is not applicable to VA patients. And because the authors investigated both routine and very complex patient care, the authors concluded that their studies provide "further evidence that NPs and PAs may be appropriately used as primary care providers, as opposed to being limited to supplement the care of physicians within primary care settings."[99]

Recent studies have also found favorable NP outcomes in states where collaboration is no longer required. A study by Jennifer Perloff and her colleagues in 2017 found that NP independence had no effect on patient outcomes, including ambulatory care-sensitive hospital admissions.[100] Another study by Jeffrey Traczynski and Victoria Udalova found that "allowing NPs to practice and prescribe drugs without physician oversight increases medical care for underserved populations and reduces ER use for conditions responsive to primary care."[101] In a study using VA data, Chuan Fen Liu and associates found "comparable or better outcomes achieved at similar costs for patients [with chronic diseases, including diabetes, IHD, and hypertension] across differing levels of comorbidity, suggesting NPs as PCPs need not be limited to less complex patients."[102] The only contrary findings deal with prescription practices,[103] especially the overprescribing of controlled substances.[104] More definitive studies on that issue are needed.

Concerns about quality of care have also led some critics to suggest that the use of mid-level providers will generate excessive medical malpractice claims.[105] But the

[97] *See* Perri A. Morgan et al., *Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients*, 38 Health Affs. 1028, 1031–32 (2019).

[98] *See Id.* at 1031.

[99] *Id.* at 1035.

[100] *See* Jennifer Perloff et al., *Association of State-Level Restrictions in Nurse Practitioner Scope of Practice with the Quality of Primary Care Provided to Medicare Beneficiaries*, 76 Med. Care Res. Rev. 597 (2019) (no effect); *see also* Morris M. Kleiner et al., *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service*, 59 J. L. & Econ. 261, 283–84 (2016) (no effect on mortality).

[101] *See* Jeffrey Traczynski & Victoria Udalova, *Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes*, 58 J. Health Econ. 90, 104 (2018).

[102] Chuan Fen Liu et al., *Outcomes of Primary Care Delivery by Nurse Practitioners: Utilization, Cost, and Quality of Care*, 55 Health Serv. Res. 178, 187 (2020).

[103] *See* Kihwan Bae et al., Maryland's Health Care Lesson for Pennsylvania: How Full Practice Authority Can Increase Access and Improve Outcome 15 (2022) (reviewing the research).

[104] *See id.* at 16–17 (collecting the studies).

[105] Bavneet Walia et al., *Increased Reliance on Physician Assistants: An Access-Quality Trade-Off?*, 10 J. Mark. Access & Health Pol'y 2030559 (2022).

data show the opposite – NPs and PAs are far less likely to have a paid malpractice claim than physicians.[106]

Critics sometimes note that many studies, until quite recently, had any of three potential limitations.[107] None of the potential shortcomings, however, warrant a different conclusion about NP or PA quality of care. The first limitation is that most of the studies used data that lacked information about the extent of physician consultation with the NPs.[108] Thus, they did not provide information about the outcomes that would occur if NPs were acting independently. However, these studies firmly established that NPs provide equivalent quality of care when in a collaborative relationship with a physician. That finding alone was a major reaffirmation of the NP model. In addition, more recent studies have looked at the care provided by NPs and PAs when they are not working under physician supervision and their findings are equally favorable, as noted above in the discussion of the VA studies and studies from states where NPs can practice independently.

Second, some researchers worry about the potentially distorting effects of a current Medicare billing practice that permits the attribution of care provided primarily by NPs and PAs to MDs. In particular, "incident to" billing allows physicians who have participated in the care of a patient to submit claims in their own name even though a mid-level practitioner provided most of the services. Because services billed in the name of an NP or PA receive only 85 percent of the physician's fee from Medicare, Medicaid, and private insurers, hospitals and

[106] Using data from the National Practitioner's Data Bank, two studies looking at the years from 1991 to 2007 and from 2005 to 2014 found that the average physician is many times more likely than an NP or PA to make a medical malpractice payment. *See* Douglas Brock et al., *Physician Assistant and Nurse Practitioner Malpractice Trends*, 74 Med. Care Res. & Rev. 613 (2016); Roderick S. Hooker et al., *Does the Employment of Physician Assistants and Nurse Practitioners Increase Liability?* 95 J. Med. Licensure & Discipline 6 (2009). Despite these statistics, a 2022 article concluded that PAs are more prone to diagnostic error than physicians are. *See* Walia et al., *supra* note 105. That conclusion is incorrect. Because PAs much less often perform surgery, their paid claims for diagnostic error form a larger fraction of their total paid claims than for physicians. On this basis, the authors concluded that "the healthcare system currently invites upon itself some level of unnecessary medical diagnostic error" by relying on providers with less training, many of whom may not have been admitted to medical school. But they misinterpret the data. Physicians have so many more paid claims per capita, that the average NP or PA's odds of a paid claim for diagnostic error are still much lower than those of the average physician.

[107] In addition to the concerns raised in the text, critics have worried about lack of generalizability from one medical setting to another. That concern should disappear as the number of studies across multiple settings grows. Another weakness is the rarity of randomized controlled studies, but the consistency of the findings using a variety of other credible research designs reduces the significance of this weakness. *See also* Isaacs & Jellinek, *supra* note 65 (concluding that physicians will not emphasize the studies on quality).

[108] *See, for example*, Kleinpell et al., *supra* note 73, at 1446 (noting that the studies "omitted information on degree of physician oversight and consultation"); Ellen McCleery et al., Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses 3–6 (2014).

practice groups have a financial incentive to bill in the physician's name.[109] And because the extent of this practice is unknown, researchers who use insurance claims databases will inevitably assign some patient care to MDs that was primarily provided by NPs or PAs. Fortunately, the policy will be tightened in 2024. Furthermore, the VA studies described above did not have this risk and still found that NPs and PAs provided equivalent quality of care.

Third, several studies have found that NPs see patients who, on average, are less complex and less acute than the patients seen by physicians.[110] As a result, some of the reviews expressing confidence in the care provided by NPs have also expressed caution about the body of research looking at NP care of complex or critical illnesses.[111] But the recent series of VA studies and the two Buerhaus Medicare studies provide preliminary reassurance on this issue; both accounted for patient severity and had positive findings.[112]

Overall, the existing research justifies the conclusion that NPs and PAs, in their areas of specialization, provide care that is the same or better than care provided by physicians. While individual studies often have weaknesses, they collectively present a strong case for NP and PA quality of care.

The positive patient outcomes generated by NPs and PAs strongly support the claim by law reformers that mid-level professionals can provide high-quality services in their area of specialization if given suitable education and experience.

10.2.2 *Impact on Affordability and Access*

A primary goal of mid-level legal licensure is to make legal representation for simple matters more affordable. As it stands now, many Americans cannot afford to hire a lawyer. Legal access reform seeks to create categories of mid-level legal providers who are trained more economically than lawyers and, as a result, can charge lower fees and work for lower salaries. But, some wonder, will it work? Will opening up a new breed of practitioner really promote access and reduce costs?

[109] *See, for example*, Peter Buerhaus et al., *Quality of Primary Care Provided to Medicare Beneficiaries by Nurse Practitioners and Physicians*, 56 Med. Care, 484, 488 (2018); Phyllis Maguire, *Split Visit Billing Rules for Physicians and NPs/PAs*, Today's Hospitalist (Jan. 2022).

[110] *See, for example*, Perri A. Morgan et al., *Factors Associated with Having a Physician, Nurse Practitioner, or Physician Assistant as Primary Care Provider for Veterans with Diabetes Mellitus*, 54 Inquiry 46958017712762 (2017) (noting that "patients with physician PCPs are modestly more medically complex than those with NP or PA PCPs"); McCleery, *supra* note 108, at 4–5.

[111] *See, for example*, Sarzynski & Barry, *supra* note 45, at 367 (noting that questions remain about complex patients); Future of Nursing 2020–2030, *supra* note 63 (finding outcome of equivalent limited to services "within scope").

[112] A related question that has not yet been studied is whether NPs and PA are appropriately referring patients whose complexity tests the limits of their training. Some state practice acts require this. *See infra* text at notes 148–149.

Here again, the story in medicine, and particularly the experience of NPs and PAs, is instructive. NPs and PAs earn roughly half the wages of primary care physicians. In May 2021, according to the Bureau of Labor Statistics, the median income for NPs was $123,780 annually,[113] and the median income for PAs was $121,530.[114] The median for family medicine physicians was $235,930[115] and for internal medicine doctors $242,190.[116] Thus, NPs generate substantially lower salaries per full-time-equivalent.

However, the savings in labor cost *per patient* are reduced because NPs and PAs have historically generated less revenue than physicians. In mixed provider groups, NPs commonly see fewer patients,[117] see patients with less complex ailments,[118] work fewer hours,[119] have longer visits,[120] and generate costs for physician oversight.[121] These factors make it difficult to calculate the precise degree to which hiring NPs saves an employer money. The calculation is further complicated by the possibility that the longer visits associated with NPs save health care costs later by generating fewer hospitalizations and less unnecessary imaging down the road.[122]

Regardless, private practice physicians regularly employ NPs and PAs (rather than more physicians) to help keep their practices profitable.[123] According to a 2009 survey for the National Center for Health Statistics, half of all office-based physicians employed advanced practice nurses or PAs.[124] A report for the Physicians Foundation explains that physicians had been "[f]aced with declining reimbursement rates and the need to increase patient volume in order to keep their practices afloat."[125] Hiring NPs and PAs allows physician practices to increase their volume at lower cost.[126] Hiring

[113] *See* Bureau of Lab. Stat., U.S. Dep't of Labor, *supra* note 48.
[114] *See* Bureau of Lab. Stat., U.S. Dep't of Labor, *supra* note 42.
[115] *See* Bureau of Lab. Stat., U.S. Dep't of Labor, *supra* note 46.
[116] *Id.*
[117] *See, for example*, Sarzynski & Barry, *supra* note 45, at 368 (reporting that MDs see 30 percent more patients than NPs and are often paid to supervise NPs); Buerhaus et al., *supra* note 109, at 14 (reporting that NPs see fewer patients per week); Liu et al., *supra* note 102, at 186 ("An NP's panel size at VA is expected to be 75 percent of an MDs in order to give NPs sufficient time to manage their patients.").
[118] *See supra* note 110.
[119] *See, for example*, Buerhaus et al., *supra* note 109, at 14 ("On average, PCNPs work fewer hours per week than PCMDs (37 hours versus 46 hours)."); Donelan et al., *supra* note 45, at 1898 (reporting that, in survey of MDs and NPs, physicians reported working longer hours).
[120] *See* Swan et al., *supra* note 73, at 396.
[121] *See* Sarzynski & Barry, *supra* note 45, at 368 (noting that MDs are often paid to supervise NPs).
[122] *See* Liu et al., *supra* note 102, at 186 ("Reduced panel size may translate to greater access and time spent with individual patients, which in turn may translate into fewer hospitalizations."); Morgan et al., *supra* note 110, at 1031 (reduced size could help explain favorable findings).
[123] *See* Isaac & Jellinek, *supra* note 65, at 10–11.
[124] *Id.* (49.1 percent).
[125] *Id.*
[126] *Id.*

NPs and PAs also allows hospital-contracted groups, like hospitalists and ER groups, to offer the hospital lower terms.[127]

To the extent that these interpretations of recent events are correct, then NPs and PAs have helped hospitals and physician groups remain viable despite the price concessions demanded by insurance companies. Those concessions may, in turn, have tempered the rise in prices paid for health care services and the premiums paid for health insurance. If so, a marginal improvement in access to health insurance and, thus, health care may have resulted.

At present, the only concrete evidence of cost reduction is found in a 2016 study that found that prices for child well-care visits were lower by 3 to 16 percent in states with independent NPs,[128] and another 2016 study finding that clinics with more nonphysicians had "lower prices for office visits."[129] The impact of NPs on prices is likely to grow as NPs begin setting up independent practices. This tempering of medical price increases improves access to medical care for uninsured middle-class patients, but it helps account for the strong political opposition of the AMA to NP independence.

NPs also increase access by providing crucial staffing for community health centers (CHCs). Community health centers' reliance on NPs and PAs has increased in recent years,[130] as these clinics have had difficulty recruiting and retaining physicians.[131] Today, over half of the primary care positions in CHCs are filled by NPs and PAs.[132] As a result, the rise of NPs and PAs has helped the clinics continue providing care to their uninsured and underinsured patients.

Urgent care clinics and retail clinics also rely heavily on mid-level health care providers. Urgent care clinics offer self-paying patients a lower-cost alternative to an ER visit.[133] Average ER visits are four to ten times more expensive than urgent care clinics depending on the patient's condition.[134] Retail clinics also reduce ER visits and

[127] *See* Maguire, *supra* note 109.

[128] *See* Kleiner et al., *supra note* 100, 261.

[129] Michael R. Richards & Daniel Polsky, *Influence of Provider Mix and Regulation on Primary Care Services Supplied to US Patients*, 11 Health Econ. Pol'y L. 193, 193 (2016).

[130] *See* Kurtzman & Barnow, *supra* note 87, at 1.

[131] *See id.* at 6 (citing R. A. Rosenblatt et al., *Shortages of Medical Personnel in Community Health Centers: Implications for Planned Expansion*, 295 JAMA 1042 (2006)).

[132] *See* Karen Eseta Mulitalo et al., *How PAs Have Brought Innovation to Primary Care*, *in* Physicians Assistants as Social Innovators in Healthcare 65, 72–73 (2022); Kurtzman & Barnow, *supra* note 87, at 1–2.

[133] *See* Lindsay Allen et al., *The Impact of Urgent Care Centers on Nonemergent Emergency Department Visits*, 56 Health Serv. Rsch. 721, 722 (2021).

> We found that having an open urgent care center in a ZIP code reduced the total number of ED visits by residents in that ZIP code by 17.2% ($P < 0.05$), due largely to decreases in visits for less emergent conditions. . . . We found that urgent care centers reduced the total number of uninsured and Medicaid visits to the ED by 21% ($P < 0.05$) and 29.1% ($P < 0.05$), respectively."

[134] *See id.* (reporting that clinic care is on average ten times less expensive); *id.* at 727 (reporting that nonemergent visits are about four times less expensive, a cost of $156 as against $570).

are primarily staffed by NPs.[135] By staffing these two kinds of storefront clinics at lower salaries than those of physicians, mid-level medical providers may be keeping retail prices for routine medical care lower than they otherwise would be. To that extent, they are improving access to care for people who are uninsured or have extremely high deductibles. Unfortunately, the magnitude of that impact remains unmeasured.

In the field of law, mid-level legal practitioners have the same potential to generate lower prices for basic services, making those services more accessible to middle-class clients. As with NPs, this beneficial pricing effect can occur regardless of whether the nonlawyer advocates work within a law firm, set up their own practices, or work for a nonprofit.

NPs and PAs have also had a positive impact on the availability of medical care in rural areas. Many studies have found that NPs and PAs are more likely than all physicians except family medicine physicians to practice in rural areas and Health Professional Shortage Areas (HPSAs).[136] Of course, the AMA vigorously denies that NPs are more likely than physicians to work in underserved areas. To prove its case, the AMA has created a geomapping computer program to demonstrate that NPs cluster in "the same geographic locations as physicians."[137] But the public cannot access this tool.

Finally, NPs are more likely to treat Medicaid beneficiaries.[138] They even improve the willingness of physicians to accept new Medicaid patients.[139]

To summarize, NPs and PAs have had a positive impact on access to care for uninsured patients. They do this most dramatically by providing essential staffing for free clinics. They also staff the relatively low-cost urgent care and retail clinics visited by many uninsured and underinsured patients. Furthermore, there are signs that the availability of NPs and PAs is tempering price increases for primary care in general. NPs and PAs have also had a positive impact on the availability of medical care in

[135] *Id.* at 722. Retail clinics lack some of the services of urgent care clinics, like repair of lacerations, but their out-of-pocket costs tend to be lower. *Id.* at 722–23.

[136] *See, for example*, *The Distribution of the U.S. Primary Care Workforce*, Agency for Healthcare Rsch. & Quality, https://www.ahrq.gov/research/findings/factsheets/primary/pcwork3/index.html (last accessed Mar. 26, 2024) (table 2); Keith B. Naylor et al., *Geographic Variation in Spatial Accessibility of U.S. Healthcare Providers*, 14 PLOS One 1 (2019) (NPs and family practice physicians more rural than other physicians as assessed by driving distance). PA distribution is also more rural than physicians. *See* Mulitalo et al., *supra* note 132, at 71–72 (collecting studies).

[137] *Health Workforce Mapper*, Am. Med. Ass'n, https://www.ama-assn.org/about/research/health-workforce-mapper (last accessed Jan. 31, 2024).

[138] *See, for example*, Peter Buerhaus et al., *Practice Characteristics of Primary Care Nurse Practitioners and Physicians*, 63 Nursing Outlook 144, 144 (2015); Jennifer Perloff et al., *Comparing the Cost of Care Provided to Medicare Beneficiaries Assigned to Primary Care Nurse Practitioners and Physicians*, 51 Health Serv. Rsch. 1407, 1414 (2016) (beneficiaries assigned to NPs were more likely to be on Medicaid).

[139] *See* Richards & Polsky, *supra* note 129, at 193 ("We find clinics with more non-physician clinicians are associated with better access for Medicaid patients and lower prices for office visits.").

rural areas. Licensed nonlawyer legal practitioners could have a similar tempering effect on prices for basic legal services. They could also provide a pool of lower-priced practitioners to staff new, innovative clinics in areas like eviction and debt collection where clients lack the funds to hire attorneys.

10.3 TYING THE PIECES TOGETHER: LESSONS FOR LAW

For law reformers looking at the experience in medicine, two positive findings stand out. First, high-quality services can, indeed, be delivered by mid-level practitioners who are trained at a lower cost than that required to train the top tier of the profession. Second, professions can exist with many kinds of limited license professions. Medicine has dozens of them. And their proliferation has not shaken the foundation of the profession. Medicine uses limited license specialists to deliver high-quality health care in a more efficient manner.

However, the field of law differs from that of medicine in at least three important ways that impose barriers to the licensing of mid-level legal practitioners. One crucial difference is the absence of a legal equivalent to health insurance. A second is the long-standing shortage of physicians. A third is the long custom of using mid-level licensed providers in medicine. As a result, physicians did not view the creation of new categories of mid-level health care providers as a zero-sum game, at least when the new tiers were under the direction of physicians. The health care marketplace provided enough patients with insurance to support both physicians and nonphysicians. As a result, physicians did not collectively oppose the creation of the NP and PA professions, nor did they oppose emergence of the professions of EMT and paramedic or the numerous categories of mental health counselors. They made no organized efforts to temper the very rapid growth in the number of NP and PA programs. Only when these mid-level providers began to ask for powers that would make them nearly equivalent to physicians did opposition intensify.

These important differences between the legal and medical markets mean that law reformers face more practical and political barriers than Loretta Ford did. This section looks first at the objections raised to limited license legal professionals and how those objections have been addressed in medicine. It then looks for strategic lessons in the successful efforts by NPs and, to a lesser extent PAs, to enact state-enabling laws.

10.3.1 *Practical and Political Barriers*

The primary objections are summarized in the committee reports of three states that rejected or tabled proposals for limited license legal professionals – Montana,[140]

[140] Minutes, *Mont. Supreme Court Access to Justice Comm'n* (Dec. 8, 2017) https://courts.mt.gov/external/supreme/boards/a2j/minutes/12-8-17min.pdf (last accessed Feb. 24, 2025) (reporting that

Illinois,[141] and Virginia.[142] My review of these reports shows that critics of nonlawyer licensure offer a few recurrent refrains:

1. Legal representation by nonlawyers will be sloppy. A two-tier system of justice will result.
2. For-profit nonlawyer advocates will not serve underserved or low-income people.
3. Limited license legal practitioners will not be able to earn a living, even if they serve primarily middle-class clients.
4. We already have an oversupply of lawyers. Mid-level licensees will threaten their livelihoods.

In this final section, I examine these concerns, against the factual template that medicine supplies.

The first and most important concern raised by opponents of limited license legal professions is the fear that nonlawyers will provide inferior representation.[143] According to this view, even matters that appear simple can be complex. While the evidence about mid-level medical professionals is reassuring, we know much less about the effectiveness of nonlawyers.[144] More research is badly needed.

The research proving that NPs and PAs had outcomes comparable to physicians literally opened doors across the country. It led directly to influential national reports from the Office of Technology Assessment in 1986 and the Institute of Medicine twice in the twentieth century. It even prompted the FTC to question the legality of limitations on medical practice. And it generated an unexpected array of allies across the health care sector.

If law reformers can produce similar proof of the quality of representation provided by nonlawyer advocates, the odds of legislative success will grow dramatically. But doing so will be difficult. Obtaining high-quality outcomes data in the

"the LLLT committee decided to recommend that Montana not pursue the LLLT model") [hereinafter Montana Minutes].

[141] 2016 Report and Recommendations of the Illinois State Bar Association's Task Force on the Future of Legal Services (Oct. 4, 2016) [hereinafter, Illinois Report].

[142] The Study Committee on the Future of Law Practice, *Report: The Study Committee on the Future of Law Practice* (Sept. 14, 2016), https://iaals.du.edu/sites/default/files/documents/publications/va_report_of_the_study_committee.pdf (last accessed Feb. 24, 2025) (appearing to take a "wait and see" approach) [hereinafter, Virginia Report].

[143] *See, for example*, Illinois Report, *supra* note 141, at 19 (explaining that the goal is to protect clients from mistakes of the ignorant and schemes of the unscrupulous).

[144] *See, for example*, Anna E. Carpenter et al., *Trial and Error: Lawyers and Nonlawyer Advocates*, 42 L. & Soc. Inquiry 1023, 1024 (2017) ("Scholars know very little about the effectiveness of nonlawyers."); Elizabeth Chambliss, *Law School Training for Licensed Legal Technicians – Implications for the Consumer Market*, 65 S.C. L. Rev. 579, 601 (2014) (explaining that "we know very little about the relative quality of different types of legal services providers").

context of small, state-specific nonlawyer programs is challenging.[145] One obstacle is the absence of large data sets like the medical records kept by Medicare and the Veterans Administration. Another is the lack of standardization across state reform proposals.[146] Innovative ideas will be needed, such as a multistate collaboration using a shared reform model.[147] Or collaboration with a large state or federal agency like the Veterans Administration using, for example, specially trained nonlawyers to assist veterans with their claims for benefits. (My law school currently uses supervised student interns to do this work.)

While we wait, the preliminary clues are reassuring. Nonlawyers do nearly as well as lawyers on simple matters.[148] Specialized training is crucially important – more even than generalized experience.[149] These findings point toward narrowly focused training on routine matters accompanied by clear boundaries on the scope of practice that mirror the training.

Limited licensure advocates can also draft their proposals in ways designed to maximize the odds of good outcomes. At the front end, simplification of judicial forms and procedures would be a wonderful start. And at the tail end, nonlawyers could be required to have in place a preexisting relationship with a practicing lawyer for swift consultations when matters become unexpectedly complex. In medicine, NPs routinely turn to MDs in the most complex cases and internists who are stumped call-in other specialists like cardiologists or urologists. In fact, the NP licensing laws in some states expressly require as much. North Dakota, for example, requires that an NP "recognize individual limits of knowledge, skills, and abilities and plan for situations beyond the licensee's expertise."[150] And New Hampshire's statute governing advanced practice registered nurses (APRNs), including NPs, states:

Each APRN shall be accountable to clients and the board:

> (b) For *recognizing limits* of knowledge and experience and planning for the management of situations beyond the APRN's expertise; and
> (c) For *consulting with or referring* clients to other health care providers as appropriate.[151]

[145] *See* Chambliss, *supra* note 144, at 602 ("Quality assessment is also impeded by the decentralized, fragmented nature of civil legal services delivery, which relies on a wide variety of delivery models in addition to private practice.").
[146] *Id.*
[147] *See* Chapter 13 in this volume.
[148] *See* Rebecca L. Sandefur, *Legal Advice from Nonlawyers: Consumer Demand, Provider Quality, and Public Harms*, 16 STAN. J. C.R. & C.L. 283, 304–05 (2020) ("Findings from a systematic review of forty years of U.S. research comparing lawyer and nonlawyer performance bear out the importance of complexity. … [W]hile nonlawyer advocates can be very good at some things, they may be not always be appropriate when clients face complex legal issues.").
[149] *Id.* at 305.
[150] N.D. Admin. Code, 54-05-03.1-03.2 (2023).
[151] N.H. Stat. 326-B:11.II (2023) (emphasis added).

Lawyers do this, too, but new nonlawyer practitioners may not know the tradition or have the relationships needed to accomplish it. To cure this, establishment of a relationship with a lawyer could be built into clinical training. Adding protective features like these may influence the votes of open-minded judges and legislators.

Finally, law reformers can improve quality control and reassure critics by borrowing from medicine and giving lawyers an oversight role. To keep costs down, one lawyer could be permitted to supervise multiple mid-level providers. This oversight need not be too costly or intrusive; it could occur at the end of each day, much like attending physicians review the charts of residents, or each week just as some supervising physicians meet with collaborating NPs.

The second important objection to the licensure of nonlawyer advocates is the belief that for-profit, mid-level legal professionals will not serve low-income people.[152] Here, the absence of an analog to health insurance is crucially important. Fees will have to be paid, and critics fear that they will be too high for low-income clients. According to a dissenting judge on the Washington Supreme Court, Washington's pilot program was "incompatible with meeting the needs of low-income individuals," and had "shifted to becoming a moderate means effort."[153] For many law reformers, this is a major shortcoming.

The problem of retail cost has led some advocates to recommend that the length and cost of training for limited licenses be reduced. This shifts the best medical analogy away from the training of NPs and PAs and toward the training of EMTs and paramedics. Their education and training are much cheaper than that of MDs, NPs, and even RNs. And their entry prerequisites are less demanding. As a result, their pay is lower and their scope of practice more limited. This may align well with some nonlawyer niches being considered by reformers.

But this option faces a couple of obstacles. One is its tension with the goal of high-quality representation. To thread the needle, the training will have to be tightly aligned with the scope of practice, as is true for many mid-level medical professionals. A second problem is that these trained and licensed "legal paramedics" may make less money than an untrained and unlicensed paralegal. If their income drops to that of paralegals, as happened for some mid-level practitioners in Washington,[154]

[152] *See* Illinois Report, *supra* note 141, at 26 ("The needs of the underserved who cannot afford to pay for legal services are likely not going to benefit from the implementation of a for-profit LLLT program."). Virginia noted the absence of data. Virginia Report, *supra* note 142, at 17 ("There is little data to measure the programs' impact on access to legal services.").

[153] *See generally In re* Proposed Amendments to APR 28–Limited License Legal Technician Rules, Order No. 25700-A-1258 (Wash. 2019) (Gonzalez, J., dissenting). His remarks are discussed in Daniels & Bowers, *supra* note 2, at 259.

[154] *See also* Thomas M. Clarke & Rebecca L. Sandefur, Preliminary Evaluation of the Washington State Limited License Legal Technician Program 13 (2017) ("A hypothetical business model that charges fees between those of a paralegal and a lawyer seems viable, but current actual fees [in Washington] are mostly the same as a traditional paralegal. Where the LLLTs are operating a pure LLLT practice, their fees tend to be moderately higher than that of paralegals.").

then potential license applicants will have no financial incentive to pay the training costs associated with the limited license.[155] But if their incomes settle higher, then low-income clients will not be able to afford their services. To serve low-income clients, subsidies will be needed.

Another strategy for surmounting the problem of retail cost is to recruit existing community advocates to become licensed mid-level legal professionals, and then to subsidize their training. This may already be happening informally in the federal agencies that allow nonlawyer representatives to assist claimants. And, in Chapter 1 of this volume, Sandefur and Burnett describe several similar state programs.[156] In Delaware and Texas, for example, nonlawyers can represent tenants and landlords. Alaska allows nonlawyer Community Justice Workers to be trained and supervised by Alaska Legal Services Corporation. Most work in remote Alaska Native communities that have no lawyers. Arizona has a Licensed Legal Advocate program for domestic violence cases. In addition, Utah has a legal safe space that it calls a "sandbox." Programs in the sandbox receive waivers from the unauthorized practice of law prohibitions. One potential advantage of these grassroots programs is their potential, not only to help underserved clients solve their legal problems but also to change their trust in, understanding of, and engagement with the law.[157]

A third objection raised by critics of limited licenses is that the holders will not be able to earn a living even if they serve primarily middle-class clients.[158] This issue did not surface in medicine because that system largely serves patients who have insurance, including Medicaid and Medicare. Consequently, salaries for mid-level medical professionals are good, jobs are plentiful, and there are more applicants for mid-level career programs than there are slots, even though the educational costs are substantial.

Because legal practice lacks any equivalent to health insurance, the financial viability of mid-level practitioners is still an open question. The experience in Washington was an inauspicious start. One review concluded that "[m]ost LLLTs struggle to attract enough clients to sustain a viable business."[159] One barrier is that consumers may be confused about the services that limited license providers are

[155] EMTs, paramedics and imaging technologists just need a high school diploma or associate degree. Would that suffice for some highly targeted nonlawyer niches as long as they first received a year of specific legal training? That idea requires considerably more thought.

[156] *See* Chapter 1 in this volume.

[157] *See id.* at 9 (recommending that objective).

[158] *See* Clarke & Sandefur, *supra* note 154, at 13; Daniels & Bowers, *supra* note 2, at 262 (observing that "sustainability has become a major concern not only in Washington State but also in other states as well"); Illinois Report, *supra* note 141, at 26–27 ("In addition, given the rise of internet based alternative legal services that provide forms and do-it-yourself services (both for-profit and non-profit), the economic viability of LLLT's may be in doubt.").

[159] *See* Clarke & Sandefur, *supra* note 154, at 13. The committee in Montana assigned to consider the issue noted that "the level of training required for the license would be a significant barrier to participation." Montana Minutes, *supra* note 140, at 3.

authorized and qualified to perform.[160] In addition, many people do not want to involve the formal legal system.[161] Others "do not understand their issues to be legal, and so do not see them as proper objects of legal action."[162] In many instances, the amounts in dispute don't warrant hiring a representative.[163]

Nevertheless, the universe of underserved middle-class Americans is so vast that the effort to serve them makes sense, even though some trial and error will be necessary to find models that work. The Institute for Advancement of the American Legal System at the University of Denver clearly thinks so.[164] It released a report in June 2023 called "Allied Legal Professionals: A National Framework," containing national recommendations to guide states considering programs to train and license a new tier of "allied legal professionals."[165] The Institute is working with three national paralegal organizations to create this national template. Its summary of the new profession closely resembles that of NPs, and they expressly make that analogy. The proposal contemplates a tier of licensed legal practitioners whose lower training costs (lower than Washington's) will make their services affordable for middle-class Americans. They recommend independence from attorney oversight, even in court. Their plan targets clients with enough purchasing power to buy lower-cost legal services.[166] Because it contemplates the recruitment of paying clients, this proposal will face intense opposition from the bar.

This prospect of competition for clients fuels the last and most incendiary objection to authorizing mid-level legal practitioners. Many members of the bar view the legalization of mid-level legal professionals as a threat to their livelihoods. For them, it is a zero-sum game.

[160] *See* Illinois Report, *supra* note 141, at 27 ("[T]he Task Force believes there is a real possibility for consumers to be misled by unsupervised LLLT's attempting to perform services they are neither qualified nor authorized to perform."); Clarke & Sandefur, *supra* note 154, at 9 ("Clients [in Washington] were sometimes confused about exactly what LLLTs could and could not do.").

[161] *See* Rebecca L. Sandefur & Matthew Burnett, *All Together Now: Building a Shared Access to Justice Research Framework for Theoretical Insight and Actionable Intelligence*, Oñati Socio-L. Ser. 1330, 1342 (July 28, 2024) https://opo.iisj.net/index.php/osls/article/view/1437, at 3 ("For many issues, people simply attempt to handle problems on their own."); Chambliss, *supra* note 144, at 587 (observing that "simply lowering rates does not address problems of consumer engagement").

[162] *See* Sandefur & Burnett, *supra* note 159, at 3.

[163] *See* Aebra Coe, *Like It or Not, Law May Open Its Doors to Nonlawyers*, Law360 (Sept. 22, 2019) (noting that a 2015 study by the National Center for State Courts "found that in many civil cases the cost of hiring a lawyer is often more expensive than the value of the amount in dispute, as three-quarters of all judgments in the state courts during the year were less than $5,100").

[164] *See Allied Legal Professionals*, Inst. for Advancement of the Am. L. Sys., https://iaals.du.edu/projects/allied-legal-professionals (last accessed Aug. 28, 2023); Michael Houlberg & Natalie Anne Knowlton, Allied Legal Professionals: A National Framework for Program Growth (2023).

[165] *See* Houlberg & Knowlton, *supra* note 164.

[166] *See id.* at 18, 28.

In medicine, the reaction of physicians to the creation of mid-level professions has been dramatically different. In that field, the various tiers of licensed health care professions facilitate the work of physicians. Their presence frees physicians to devote time to services that are more remunerative. For example, PAs can handle post-op clinic visits while the supervising physicians perform more procedures. Hospital nurses can provide the continuous patient care that the admitting physicians require. And insurance pays for it all. In short, the widespread presence of health insurance and the shortage of physicians combine to produce a dramatically different climate for the deployment of mid-level professionals.[167] That fabric of cooperation has only recently frayed as NPs and then PAs have begun to seek full independence from physicians and, thus, the ability to threaten the business of physicians.

In the debate over law reform, many members of the bar already see a threat to their business. And they are responding as many physicians have done to the call for full NP independence.

10.3.2 *Lessons from the Successful Law Reform Efforts in Medicine*

Justice reformers could potentially reduce the pushback from practicing lawyers by borrowing from the initial NP and PA profiles and designing plans that provide some benefit to practicing lawyers. This will be a controversial tactic. But the potential tactical value makes it worth consideration. For example, the practice act could mandate one supervising lawyer for every five community law workers. As noted above, this supervision need not be very expensive or intrusive.[168]

A second way to borrow from the successful experience in medicine is to create boundaries on the new profession's scope of practice that reduce the perceived threat to practicing lawyers. Practicing lawyers can help identify the niches that they cannot afford to serve, and their acquiescence will materially improve the odds of legislative success.

Unfortunately, none of this is likely to soften the plight of most unemployed or underemployed lawyers. Indeed, some critics of limited licenses seem to be asking that we put young lawyers to work before adding to the supply of legal practitioners. But these lawyers could already be serving the needs of these clients if they felt they could make a living doing so. Legal services are simply too expensive for a self-pay

[167] Law reformers do not seek a status equivalent to lawyers (with the possible exception of the Institute's proposal for Legal Practitioners). In that respect, their proposals are more like the original plans to create the NP and PA fields or the EMT and paramedic professions.

[168] At the same time, this arrangement will have the very beneficial effect of requiring the *ex ante* establishment of a relationship between each mid-level provider and a practicing attorney. That will ensure that each community advocate knows a lawyer to whom unexpectedly complex cases can be referred.

market. There are no lessons in medicine for solving this dilemma. Some kind of financial assistance will be necessary.

Practicing lawyers and reformers will have their fiercest fights over those clients whose incomes place them near the border between those who can afford to hire a lawyer and those who can't. The closer that a proposal for nonlawyer licensure comes to that border, the fiercer the opposition will be. And the less critical the new license will be. It would be very helpful to have more information about the characteristics of this boundary territory.

The legislative success of NPs over the past sixty years also suggests one additional tactic that has nothing to do with the merits of the proposal. That tactic is to nationalize the campaign for mid-level lawyer services. That means establishing one or more national organizations whose job it is to doggedly recruit allies, develop and promulgate a consistent narrative, and develop leaders. It can also draft model legislation. The Institute for Advancement of the American Legal System at the University of Denver may be angling for this role.

One of the organization's jobs should be recruitment of allies in the federal agencies. This "federalizing" strategy proved very beneficial for NPs and PAs. In 1977, the American Nurses Association had its first success in Washington, D.C. Congress passed the Rural Health Clinic Act of 1977 providing funding to increase the use of NPs and PAs working in rural health centers. It required that 50 percent of services in these clinics come from NPs and PAs.[169] Next, Elliott Richardson, the Secretary of Health, Education and Welfare, established the Committee to Study Extended Roles for Nurses to consider the feasibility of expanding nursing practice. In 1971, the committee recommended expanding the use of NPs.[170] One result was increased federal funding for the training of NPs in areas such as family, adult, and emergency practice.[171] In 1986, the Office of Technology Assessment published a comprehensive literature review concluding that NPs and PAs in primary and ambulatory care provided care as good as the care provided by physicians "within their areas of competence."[172]

In 1989, President George H. W. Bush signed the Omnibus Reconciliation Act authorizing federal reimbursement for NPs in rural areas outside of health clinics.[173]

[169] *See* Hooker & Carter, *supra* note 38, at 30; Nira Al-Agba & Rebekah Bernard, Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant in Healthcare 4 (2020).

[170] *See* U.S. Dep't of Health, Educ. & Welfare, Extending the Scope of Nursing Practice: A Report of the Secretary's Committee to Study Extended Roles for Nurses 4, 12 (1971) (declaring that "we believe that extending the scope of nursing practice is essential").

[171] Arlene W. Keeling, *Historical Perspectives on an Expanded Role for Nursing*, 20 OJIN: Online J. of Issues in Nursing (May 31, 2015), https://ojin.nursingworld.org/table-of-contents/volume-20-2015/number-2-may-2015/historical-perspectives-expanded-role-nursing/ (last accessed Feb. 24, 2025).

[172] *See* Office of Technology Assessment, *supra* note 74, at 5.

[173] *See* Al-Agba & Bernard, *supra* note 169, at 4.

A decade later, President Clinton signed the Budget Reconciliation Act of 1997, allowing Medicare to pay for NP services regardless of geographic location. In that same year, the Robert Wood Johnson Foundation began to fund Executive Nurse Health Policy Fellowships to place nurses in positions of policy leadership at the state and national levels.[174]

In 2010 the Institute of Medicine published an influential report called *The Future of Nursing* in which it recommended expanded NP scope of authority.[175] In 2012, the National Governors Association concluded that NP care was comparable to physician care and called for loosening of restrictions on the practice.[176] Two years later, the FTC concluded that restrictions on practice were no longer needed and could be anticompetitive.[177]

Following enactment of the Affordable Care Act of 2010 and the *Future of Nursing*, the Robert Wood Johnson Foundation allied with the AARP to launch *The Future of Nursing: Campaign for Action*, a nationwide initiative for state law reform.[178] As noted above, NPs now have full practice authority in the majority of states.

In a similar vein, today's law reformers can build on the federalizing efforts that others have already begun. Several federal agencies have welcomed nonlawyer representatives who assist beneficiaries who are very often overwhelmed by the bureaucratic process. Much more of that is possible.

Once the effort has allies, a narrative, and great outcomes, the prospects for further reform legislation will be much improved. So too will the odds of funding to subsidize low-income clients.

10.4 CONCLUSION

High-quality services can be delivered by mid-level practitioners who are trained at a lower cost than that required to train the top tier of the profession. Medicine has dozens of these professions – and has had them for over a century. The two examined in this chapter – NPs and PAs – have patient outcomes that equal those of physicians. Moreover, researchers have repeated these positive findings in a wide variety of settings using many different methods and metrics. In addition, NPs and

[174] *See id.* at 5.
[175] *See* The Future of Nursing 2010, *supra* note 58.
[176] *See* Nat'l Governors Ass'n, *supra* note 62, at 11 (concluding that NP care is comparable to that of physician care and that "states might consider changing scope of practice restrictions and assuring adequate reimbursement for their services as a way of incentivizing greater NP involvement in the provision of primary care").
[177] *See* Gilman & Koslov, *supra* note 61.
[178] *State Implementation Program*, Robert Wood Johnson Found., https://ccna7.vermilion.com/our-network/grantee-and-award-programs/state-implementation-program/ (last accessed Apr. 30, 2023).

PAs provide this care at lower cost than physicians and in underserved areas where it is difficult to recruit physicians.

Now law reformers are creating and evaluating new mid-level licenses in the field of law. If the early outcomes are good, then ensuing proposals can be drafted with provisions designed to convince doubters that quality will be high.

Because the law has no analog to health insurance, however, the programs will also have to bring fees down. To do so, training programs will need to be lean and focused. Trial and error will eventually reveal some good ones. Once models that offer excellent outcomes at substantially reduced cost are developed, the search for sustainable funding will be much easier.