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INTRODUCING PATIENT SCOPE OF CARE: PSYCHOLOGISTS, PSYCHIATRISTS, AND THE PRIVILEGE TO PRESCRIBE DRUGS

I. INTRODUCTION

States regulate healthcare through their police power to protect the public's health and welfare.¹ To achieve this end, policymakers enact state healthcare laws in pursuit of improving quality, increasing access, and controlling the costs of healthcare services for patients.² Doctors have historically played an active role in the development of state licensure and scope of practice laws, resulting in a highly self-regulated profession.³ This, coupled with legislators' limited expertise in the area of healthcare, forces state actors to rely on healthcare professionals in legal decision-making.⁴ The healthcare professionals are motivated by self-interests and fight to dictate what constitutes quality, access, and cost in an effort to advance underlying professional biases.⁵ Thus, the debate over scope of practice is framed exclusively from the healthcare professionals' perspectives and reduces to boundary drawing and line pushing.⁶ This framework fails to consider an essential factor, what I am describing as "scope of care," defined as the range of treatments available to the public from the patient's point of view.⁷ This missing perspective raises concerns about whether the existing structure of the debates can realize the intended healthcare policy goals of protecting the public's health and welfare.⁸

The history of midwifery exemplifies the importance of considering the patient's scope of care in healthcare professionals' scope of practice policy

1. Michael H. Cohen, *Holistic Health Care: Including Alternative and Complimentary Medicine in Insurance and Regulatory Schemes*, 38 ARIZ. L. REV. 83, 87 (1996).

2. John F. Hoadley, *Health Care in the United States: Access, Costs, and Quality*, 20 POL. SCI. & POL. 197, 197 (1987).

3. See *infra* Part II.A.

4. Barbara J. Safriet, *Closing the Gap Between Can and May in Health-Care Providers' Scope of Practice: A Primer for Policymakers*, 19 YALE J. ON REG. 301, 304-05 (2002).

5. Patrick M. Callahan, *Power Allocations and Professional Hierarchy in the Illinois Health Care System*, 13 DEPAUL J. HEALTH CARE L. 217, 219, 224, 229 (2010).

6. See Safriet, *supra* note 4, at 331.

7. See *infra* Part III. "Scope of care" is a concept I developed after researching the history of midwifery and scope of practice law.

8. See Lisa E. Bartra, Comment, *Reconsidering the Regulation of Health Professionals in Kansas*, KAN J.L. & PUB. POL'Y, Spring 1996, at 155, 155.

debates.⁹ Obstetricians successfully framed their territorial claim to childbirth in terms of quality, claiming midwives' practice threatened the safety of the mother and child.¹⁰ Policymakers failed to consider how the long-term effect of the change in practice would narrow patients' scope of care, resulting in a public demand for the revitalization of midwifery.¹¹

The current debate over expanding psychologists' scope of practice to include the authority to prescribe psychotropic drugs (RxP) involves a similar aspect of turf control. The debate is framed from the perspectives of self-interested actors, including psychologists, psychiatrists, and professional organizations.¹² Proponents of RxP, who have much to gain financially with expanded scope of practice,¹³ frame their arguments in terms of increased access to mental health treatment and improved quality.¹⁴ Opponents, motivated by territorial incentive to protect their exclusive power to practice medicine and economic stature from infringing psychologists,¹⁵ define their position in terms of concerns for quality and patient safety.¹⁶

What seems to be missing from both sides is consideration of the long-term effect of such regulation on the patient's scope of care.¹⁷ By applying insights gained from the history of midwifery, state legislatures will learn that RxP may not realize the quality, access, and cost policy goals championed by proponents.¹⁸ Rather, RxP will cost patients much more than currently considered in terms of the models of care available, the identity of psychology, and the standards required to obtain prescriber status.¹⁹ It will diminish quality and reduce access to care, narrowing the scope of care available to mental health patients.²⁰

9. See *infra* Part III.

10. Sarah Anne Stover, Note, *Born by the Woman, Caught by the Midwife: The Case for Legalizing Direct-Entry Midwifery in All Fifty States*, 21 HEALTH MATRIX 307, 315 (2011).

11. See *infra* Part III.B.

12. See *infra* Part IV.

13. Steven C. Hayes et al., *Prescription Privileges for Psychologists: Constituencies and Conflicts*, 58 J. CLINICAL PSYCHOL. 697, 705 (2002).

14. Letter from Katherine Nordal, Exec. Dir. for Prof'l Practice, Am. Psychological Ass'n, to Senator Delbert Scott, Senator Jane Cunningham, Mo. Senate Fin. & Governmental Org. and Elections Comm. 3, 5 (Feb. 6, 2009), available at <http://apadivision55.intuitwebsites.com/APAPDTestimony.pdf>.

15. See, e.g., Safriet, *supra* note 4, at 309.

16. See, e.g., Daniel Mamah, *Psychologist Prescribing Bill Introduced Again in 2009*, E. MO. PSYCHIATRY, 1st Q., 2009, at 1, 9, available at <http://missouri.psych.org/news/Documents/20091stQuarterNewsletter.pdf>.

17. See, e.g., Nordal, *supra* note 14; Mamah, *supra* note 16, at 9.

18. See *infra* Part V.

19. See *infra* Part V.

20. See *infra* Part V.

In this comment, I discuss the importance of adding the “scope of care” factor to the scope of practice debate regarding RxP, paying particular attention to Missouri laws. My intent is to contribute another element to recurring scope of practice debates that considers the scope of care available to the patient. The comment begins by reviewing doctors’ involvement in the history of licensure and scope of practice laws, which is characterized by the omission of patient scope of care from legal decision-making.²¹ In Part III, I offer the legal history of midwifery as an historic example of how licensure and scope of practice laws can narrow patient scope of care and result in public demand for a re-broadened scope of care. With this frame in place, Part IV addresses the current debate over psychologists’ privilege to prescribe. The scope of practice debate centers on issues of access, quality, and cost, but it omits from consideration the long-term effects on scope of care.²² In Part V, I apply insights gained from the history of midwifery to conclude that legislatures should deny psychologists the authority to prescribe. The long-term effects of granting psychologists the authority to prescribe on mental health treatment will result in a narrowed patient scope of care, and hence, an undermining of the needs of the very patients these debates are purported to serve.

II. EVOLUTION OF LICENSURE AND SCOPE OF PRACTICE LAWS

States regulate healthcare professionals’ licensure and scope of practice laws under their Tenth Amendment²³ police power to protect the health, safety, and welfare of their citizens.²⁴ These laws typically regulate healthcare professionals by defining the particular practice of the specific profession,²⁵ establishing licensing boards for various professions,²⁶ delegating regulatory functions to the board,²⁷ limiting the defined practices of the qualified people who carry a particular title,²⁸ and restricting the use of the defined practices to that profession, as well as the use of the professional title.²⁹ Any legislative decision modifying licensure and scope of

21. See *infra* Part II.

22. See *infra* Part IV.B.

23. U.S. CONST. amend. X.

24. Cohen, *supra* note 1, at 87.

25. Safriet, *supra* note 4, at 306.

26. Bartra, *supra* note 8, at 158. Allied professions are sometimes regulated by the dominant profession’s board. *Id.* at 158-59.

27. *Id.* at 158. Such functions include the authority to decide specific education and training necessary to satisfy the statutory requirements, prepare and administer the examinations required by the statute, and set standards of practice for the profession. *Id.*

28. Safriet, *supra* note 4, at 306.

29. *Id.*; Bartra, *supra* note 8, at 156.

practice laws has the potential to result in an “overall negative or positive outcome for patients.”³⁰

Doctors’ involvement in establishing physician licensure laws and their continuously active presence has played an essential role in how healthcare professional licensure and scope of practice laws developed into their current existence.³¹ Since the earliest laws, doctors have claimed the practice of medicine as their exclusive turf, forcing other healthcare professionals to define a distinct space for themselves to seek legal professional protection.³² This boundary drawing and line pushing between various healthcare professionals positions them against one another and invites them to dominate scope of practice debates.³³ Driven by self-interests, doctors and other healthcare professionals play tug of war, framing their arguments in terms of improving quality, increasing access, and controlling costs of healthcare.³⁴ This framework addresses concerns that dominate media coverage and attract legislative decision-makers’ attention.³⁵ It also creates an approach to scope of practice laws that relies on the professionals’ perspectives and requires the public to place confidence in healthcare professionals to act in their best interest.³⁶ It leaves little room for consideration of how setting boundaries and redrawing lines affects the patient’s scope of care, which should be the state’s ultimate focus in its regulation.³⁷

A. *History of Licensure Laws: The Doctor’s Role*

Medical doctors led the initial efforts to enact licensure laws in the United States as a protectionist measure against untrained practitioners.³⁸ The profession consisted of two types of medical professionals: practicing clinical doctors and doctors who were in charge of medical schools and licensure boards.³⁹ In the mid-1700s, medical doctors sought to distinguish themselves from other professionals by attending medical school and drawing a legally-defined boundary between themselves and the threat of

30. BARRY R. FURROW ET AL., *HEALTH LAW CASES, MATERIALS AND PROBLEMS* 115 (6th ed. 2008).

31. Randall G. Holcombe, *Eliminating Scope of Practice and Licensing Laws to Improve Health Care*, 31 J.L. MED. & ETHICS 236, 240 (2003).

32. See Safriet, *supra* note 4, at 306.

33. Callahan, *supra* note 5, at 219.

34. *Id.* at 229; see FURROW ET AL., *supra* note 30, at 115.

35. Safriet, *supra* note 4, at 302.

36. David M. Mirvis, *Physicians’ Autonomy – The Relation Between Public and Professional Expectations*, 328 NEW ENG. J. MED. 1346, 1347 (1993).

37. See *infra* note 65.

38. Holcombe, *supra* note 31, at 240-41.

39. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 44 (1982).

quackery through licensure laws.⁴⁰ Initially, the two sects of doctors' purposes were split in their crusade for licensure laws, but both groups had "immediate interests" in legal protection.⁴¹

Practicing clinical doctors sought to keep the profession restricted to assert their elite status, while doctors in charge of medical schools and licensing board doctors conspired to expand the profession to maximize financial gains from licensing the highest number of people.⁴² Neither type of doctor held the ultimate authority, making effective regulation impossible.⁴³ Through the early 1800s, doctors' self-interested attempts to define boundaries that distinguished the medical profession based on medical school graduates versus nongraduates, licensed versus unlicensed professionals, and medical society members versus nonmembers proved ineffective.⁴⁴ These differences in professional interests faded as physicians as a whole began to realize the need to assert a collective interest in distinguishing themselves from untrained practitioners.⁴⁵

Although physicians organized into a unified interest group seeking legal protection, their attempts to establish exclusive privileges in the mid-1800s were met by public disdain.⁴⁶ The public saw licensure laws as contradictory of democratic ideals of accessibility and universality of medicine.⁴⁷ Doctors posited they "feared the danger quacks and pretenders posed to the innocent public" while skeptics trusted the "good sense of the public" to make its own choices in seeking medical care.⁴⁸ In response to public opposition, state governments rescinded several of the initial licensure laws doctors had worked to put in place.⁴⁹

Over time, the medical profession established itself as a science-based profession, and the public began to accept both the complexity of medical

40. *Id.* at 41, 44, 45.

41. *See id.* at 45.

42. *Id.*

43. *Id.*

44. STARR, *supra* note 39, at 46.

45. *See id.* at 45.

46. *Id.* at 57-58.

47. *Id.* at 59. In the 1830s and 1840s, Jacksonian ideology made abolishing licensing professionals a high priority as the public came to see licensing as an artificial distinction expressing "favor rather than competence." *Id.* at 58. With the decline in medical licensing, physicians and irregular practitioners created societies to distinguish themselves from one another. *Id.* Physicians defined the "issue" as science versus quackery, framing it as a danger irregulars posed to the innocent public, while irregulars saw the problem in terms of free competition versus monopoly, arguing that the public was able to be free to make its own health care choices. *Id.*

48. *Id.*

49. STARR, *supra* note 39, at 58.

science and the limitation of lay competence.⁵⁰ By the 1870s and 1880s, science changed the context in which medicine was understood, and various sectarian physicians were able to unite successfully to protect themselves and the public against external, unqualified, competing practitioners.⁵¹ The public accepted the resurgence of licensure laws and viewed them as protection from corporate interests that were coming to dominate American economics.⁵²

In affirming the public perception that “few can judge of the qualifications of learning and skill, which . . . [the doctor] possesses,” the Supreme Court confirmed states’ power to regulate in the area of healthcare licensure and scope of practice.⁵³ The Court emphasized the importance of drawing the distinction between those who are qualified to practice medicine and those who are not in order to protect public safety.⁵⁴ In the 1889 *Dent v. West Virginia* case, the Supreme Court upheld a West Virginia statute requiring every doctor to obtain a medical degree from a reputable school and pass an examination.⁵⁵ The Court found that “the power of the state to provide for the general welfare of its people” authorized West Virginia to prescribe regulations aimed at securing its citizens against ignorance and incapacity. It also found the interest to be particularly compelling in the area of medicine.⁵⁶ Thus, the Supreme Court made clear that under the Tenth Amendment power to protect the health, safety, and welfare of its citizens, states could regulate the healthcare profession through licensing and scope of practice laws.⁵⁷

Since then, doctors have legally controlled the practice of medicine as exclusively theirs⁵⁸ and have dictated the way medicine is practiced within a state through state medical boards.⁵⁹ Under Missouri law, it is “unlawful for any person not now a registered physician within the meaning of the law to

50. *Id.* at 59.

51. *Id.* at 102.

52. *Id.* at 103. Licensure law had become part of the resistance of independent professionals and small business to corporate America. *Id.*

53. *Dent v. West Virginia*, 129 U.S. 114, 122-23 (1889).

54. *Id.* at 123.

55. *Id.* at 115, 128. These two requirements have become the standard minimum for most states’ medical licensure. STARR, *supra* note 39, at 104. In *Dent*, the West Virginia board of health refused to license Frank Dent as a medical doctor based on a state statute because he attended the American Medical Eclectic College of Cincinnati, a university that “did not come under the word ‘reputable.’” *Dent*, 129 U.S. at 118. Dent challenged the statute and lost. *Id.* at 128.

56. *Dent*, 129 U.S. at 122-23.

57. Stover, *supra* note 10, at 321-22.

58. Safriet, *supra* note 4, at 307.

59. Callahan, *supra* note 5, at 220.

practice medicine.”⁶⁰ The Missouri Board of Healing Arts holds the tremendous power to deny, revoke, suspend, and reinstate a medical professional’s medical license.⁶¹ The Board is composed of nine members, eight of whom are “duly licensed and registered as physicians and surgeons pursuant to the laws of th[e] state.”⁶² The resulting “primacy” of the medical profession has enabled doctors to obtain the strategic position of control over healthcare institutions and non-physician healthcare professionals.⁶³

Healthcare providers who are deemed subordinate to physicians have faced few obstacles in obtaining professional licensure protection,⁶⁴ while healthcare providers who have not been perceived as inferior but, rather, as external to and separate from doctors’ practices have faced challenges in their efforts to acquire legal recognition and protection of their profession through licensure laws.⁶⁵ Such external professionals have been forced to carve out a piece of doctors’ domain and define and re-define their practices as distinct from the practice of medicine.⁶⁶ Today, as technology advances,⁶⁷ education and training become more sophisticated, and skills grow, healthcare professionals increasingly seek expanded scopes of practice under state law.⁶⁸ The implications of legally altering a professional group’s scope of practice affect the relative status and dominion of various healthcare professionals.⁶⁹ Therefore, those healthcare professionals who are likely to be affected by scope of practice changes launch campaigns

60. MO. REV. STAT. § 334.010 (2000).

61. *Id.* § 334.100.

62. *Id.* § 334.120. The ninth member is a “voting public member, to be appointed by the governor by and with the advice and consent of the senate.” *Id.*

63. Callahan, *supra* note 5, at 220-21; see, e.g., STARR, *supra* note 39, at 221 (outlining an example of doctors maintaining their superiority in the profession despite medical advances allowing less trained individuals from providing treatment).

64. STARR, *supra* note 39, at 223. Because subordinate professional institutions developed under the aegis of physicians, health care occupations that are subordinate to doctors’ positions did not pose as great a threat to doctors’ exclusive control of the practice of medicine. *Id.* Thus, nurse midwives, nurse practitioners, and physician assistants faced little resistance in achieving licensure protection and scope of practice authorization because these professionals practice directly under the supervision and authority of medical doctors. See *id.*; see also MO. REV. STAT. § 334.104.

65. Safriet, *supra* note 4, at 308-09. Health care professionals have to defend their abilities to perform tasks safely from attacks by medical doctors who seek to defend their territory. *Id.* Throughout history, lay medical practitioners have “been either absorbed into the medical profession, like botanic medicine, or kept on the margins, like osteopathy and chiropractic.” STARR, *supra* note 39, at 48. Lay practice is an “extension of domestic care into the community.” *Id.*

66. Safriet, *supra* note 4, at 308-09; Bartra, *supra* note 8, at 156.

67. Callahan, *supra* note 5, at 219.

68. Safriet, *supra* note 4, at 308-09.

69. Callahan, *supra* note 5, at 224.

ostensibly to protect the public welfare but that actually advance self-interests, many times at the expense of the public.⁷⁰ The public voice that was concerned with protecting the citizen's voice and right of choice in medical treatment options in the mid-1800s has been swallowed by the current patchwork of licensure and scope of practice laws⁷¹ that focus on boundary drawing and line pushing.⁷²

B. Framing Scope of Practice Legal Debates

The debates over licensure and scope of practice laws center on healthcare policy considerations of access, quality, and cost from the professionals' points of view.⁷³ While the primary purpose of state regulation is to protect against uninformed decision-making that could result in harm to the patient,⁷⁴ this policy goal has been "eclipsed by a tacit goal of protecting the professions' economic prerogatives."⁷⁵ In an effort to protect their exclusive turf of practicing medicine,⁷⁶ doctors argue that healthcare providers seeking expanded scopes of practice are not properly trained and, therefore, pose a risk to patient safety and threaten healthcare quality.⁷⁷ Non-medical healthcare professionals argue expanded scope of practice would increase access by creating more providers and ultimately reduce costs to patients by offering the same services at lower fees.⁷⁸ Both sides act to protect their own self-interests and fight to define what best protects the public's welfare,⁷⁹ resulting in professional agencies "bitterly scrambling for control."⁸⁰

Legal scholars and reformers have raised fundamental concerns about the dominant role healthcare providers play in the debate, arguing that it has frustrated the realization of ultimate healthcare policy goals of improving quality, increasing access, and controlling costs to protect the

70. *Id.* at 224-25.

71. Bartra, *supra* note 8, at 155.

72. *Id.* at 156; see Safriet, *supra* note 4, at 308.

73. Callahan, *supra* note 5, at 219.

74. Bartra, *supra* note 8, at 161.

75. PEW HEALTH PROFESSIONS COMM'N, TASKFORCE ON HEALTH CARE WORKFORCE REGULATION, STRENGTHENING CONSUMER PROTECTION: PRIORITIES FOR HEALTH CARE WORKFORCE REGULATION 2 (1998). "Self interest on the part of the regulated professions, rather than public safety, can be the driving force behind regulations." Bartra, *supra* note 8, at 155.

76. Safriet, *supra* note 4, at 302.

77. *Id.* at 310.

78. Callahan, *supra* note 5, at 232.

79. Compare Mamah, *supra* note 16, at 1, 9 (arguing that RxP puts patients at risk and, thus, does not protect the public welfare), with Nordal, *supra* note 14, at 1 (positing that RxP would increase access to mental health treatment and, thus, serves the public's best interest).

80. Callahan, *supra* note 5, at 218.

public's welfare.⁸¹ Critics of current licensure and scope of practice laws believe the laws act as a barrier to entry to protect professionals' statuses instead of an assurance of quality care for the patient.⁸² They maintain that licensure and scope of practice laws have evolved into a system that is static and incapable of accommodating change.⁸³ Reformers question medical professionals' true interests and seek to limit the autonomy and power doctors hold in legal decision-making about professional licensure and scope of practice.⁸⁴ Others advocate for a fresh approach to licensure and scope of practice laws that is both the product of rational development and replaces the existing patchwork of licensure provisions that fail to create a comprehensive policy to achieve ultimate policy goals.⁸⁵

Licensure and scope of practice debates focus on the perspective of the healthcare professionals and omit consideration of the long-term effects on the patient's scope of care. State actors' primary purpose is to "establish standards that protect consumers from incompetent practitioners."⁸⁶ These laws dictate that state legislatures should settle scope of practice debates by enabling all professionals capable of providing a particular practice with quality care to have the practice incorporated into their scope of practice.⁸⁷ Skeptics question whether this paternalistic approach can actually achieve best outcomes.⁸⁸ Critics find the idea that healthcare consumers need state protection from untrained practitioners reinforces questionable assumptions of patient inability to evaluate the quality of medical care⁸⁹ and places too

81. The process of defining scope of practice is "both imperfect, and continuous." *Id.* at 219. At one extreme, Holcombe posits that licensure and scope of practice laws are "unnecessary" because they "raise the cost of health care and lower its quality." Holcombe, *supra* note 31, at 236.

82. Holcombe, *supra* note 31, at 244; Bartra, *supra* note 26, at 155.

83. See Safriet, *supra* note 4, at 309.

84. STARR, *supra* note 39, at 390-91. However, much of the autonomy and power that inheres in being a physician is reinforced through the licensing system that reproduces authority through the generations and disperses it to individual members of the profession. *Id.* at 19.

85. Bartra, *supra* note 8, at 155.

86. PEW HEALTH PROFESSIONS COMM'N, *supra* note 75, at 2.

87. See Callahan, *supra* note 5, at 231. State regulators should consider how costs are affected when considering laws that confine or broaden health care professionals' scopes of practice. *Id.* at 231-32. "Those in the position to regulate the professional hierarchy in the healthcare system ought to seek out resolutions that favor patients' access to care." *Id.* at 234.

88. Peter Morrison, Note, *Adjusting The Role of Chiropractors in the United States: Why Narrowing Chiropractor Scope of Practice Statutes will Protect Patients*, 19 HEALTH MATRIX 493, 533 (2009).

89. See *id.*

much trust in doctors.⁹⁰ Yet, undoubtedly, some state protection is necessary.⁹¹

The current approach only considers the professions' voices in the debate at the expense of the public's interest. Ignoring the perspective regarding the long-term effect on the patient's scope of care can result in a narrowed scope of care and a failure to realize the states' policy goal to protect the public's welfare. Ultimately, this ignorance will lead to a public demand for broadened approaches to healthcare treatment options and a backlash in response to failed policy considerations as exemplified by the legal history of midwifery in the United States.

III. LESSONS FROM LEGAL HISTORY: MIDWIFERY IN THE UNITED STATES

The legal history of midwifery offers an historic example of how licensure and scope of practice laws have failed to consider patient scope of care in defining who could legally practice child delivery. Doctors used their status as a unique holder of complex medical knowledge to dictate the definition of delivery as a practice within the scope of medicine and exclude direct-entry midwives from the practice.⁹² Claiming that midwives' approach to childbirth was unsafe and posed a threat to the life of the mother and child, obstetricians used licensure law to displace direct-entry midwives and narrow the scope of care afforded to pregnant women.⁹³ However, the movement toward the hospital setting as the best option for the public's safety ignored the long-term effect this change would have on the patient's scope of care and afforded great deference to the healthcare professionals' arguments.⁹⁴ Omitting the perspective for the patient's scope of care has led to a public demand for a broadened scope of care through the revitalization of midwives' services.⁹⁵ Today, direct-entry midwives are successfully gaining legal recognition and protection of their practice through state law as a response to the public's demand for an alternative to professionalized childbirth.⁹⁶ The shift towards legal recognition suggests that scope of practice debates should include a perspective for the long-term effects on the patient's scope of care to enable states to ultimately achieve their public policy healthcare goals of protecting the public's health and welfare.

90. Stover, *supra* note 10, at 322.

91. Morrison, *supra* note 88, at 533.

92. Stover, *supra* note 10, at 314, 342.

93. *Id.* at 315-16.

94. See *id.* at 329 (discussing a study in which births in the hospital setting were characterized by much higher rates of complicated medical intervention, exacerbating the long-term health risks to pregnant women).

95. *Id.* at 317.

96. See *id.*

A. Early Practice of Midwifery

Traditionally, direct-entry midwives relied on self-education in their training by observing deliveries attended by experienced midwives and completing apprenticeships. Gradually, the midwife would assume a more active presence at childbirth.⁹⁷ Today, this traditional approach is often coupled with school training;⁹⁸ however, it is still distinct from medical-based training obtained through the discipline of nurse midwifery.⁹⁹ Nurse midwives must earn a nursing degree and then complete additional coursework in gynecology and obstetrics before being certified to attend deliveries.¹⁰⁰ Certified nurse-midwives are authorized to practice in every state and can practice in hospital settings under the direct supervision of physicians.¹⁰¹

For almost 250 years, direct-entry midwives were essentially the exclusive provider of pregnancy healthcare.¹⁰² Pregnant women would call in a circle of female family members and friends to attend the childbirth as a communal event, and the midwife would offer emotional and practical support during the birth.¹⁰³ Childbirth was a social event, not a medical one.¹⁰⁴ The midwife's purpose was to provide emotional and practical support to the mother who was in control of delivery herself.¹⁰⁵ Midwives' approach viewed pregnancy as normal and part of the woman.¹⁰⁶ Childbirth was "technologically simplistic."¹⁰⁷ The lack of drugs and surgical instruments meant doctors did not have a competitive advantage over midwives, and the two professions peacefully co-existed in their practices of childbirth.¹⁰⁸ In fact, midwives were exempted from the earliest licensing laws that threatened legal sanctions for the unlicensed practice of medicine.¹⁰⁹

97. Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 *CARDOZO WOMEN'S L.J.* 61, 63, 68-69 (2004).

98. *Id.* at 68-69.

99. Stover, *supra* note 10, at 309.

100. Tovino, *supra* note 97, at 69.

101. *Id.*

102. Stover, *supra* note 10, at 313.

103. STARR, *supra* note 39, at 49.

104. Suzanne Hope Suarez, *Midwifery is Not the Practice of Medicine*, 5 *YALE J.L. & FEMINISM* 315, 325-26 (1993).

105. *Id.* at 331; STARR, *supra* note 39, at 49.

106. Suarez, *supra* note 104, at 336.

107. Suarez, *supra* note 104, at 336.

108. Tovino, *supra* note 97, at 64.

109. STARR, *supra* note 39, at 45.

However, as the medical profession evolved scientifically, doctors “[transformed] childbirth into a medical/scientific event.”¹¹⁰ Evolving anatomical medical knowledge and the introduction of the forceps, which shortened the labor process, initiated the decline of midwives in the late 1700s.¹¹¹ Beginning in the 1760s, doctors used their status as holders of complex scientific knowledge to convince women that midwives were inadequately prepared to handle deliveries.¹¹² Positing there was no such thing as a normal pregnancy,¹¹³ doctors framed direct-entry midwives as posing a serious threat to the safety of the mother and her baby.¹¹⁴ Because midwives as a profession lacked political organization and clout, legal action to exclude midwives from the practice of childbirth was essentially unopposed.¹¹⁵ Following the general public trend toward appreciation for physicians’ professional knowledge during the time,¹¹⁶ upper-class women accepted physicians’ assertions that they possessed superior ability and skill at delivering babies¹¹⁷ and joined the obstetricians’ campaign against direct-entry midwives.¹¹⁸ Eventually, all women acquiesced to doctors’ desired demand for the “higher standard of obstetrics”¹¹⁹ to “alleviate the risks of childbirth.”¹²⁰

This framework not only convinced women that obstetricians were better qualified for delivery, but also influenced judicial decision-making. Judges deferred to state legislatures, who in turn deferred to doctors who articulated concern for the mother and child’s safety. In Massachusetts, the court found that the Medical Practice Act of 1894,¹²¹ which established guidelines for examining and licensing doctors and classified obstetrics as medicine, was constitutional because “[t]he maintenance of a high standard of professional qualifications for physicians is of vital concern to public health.”¹²² This concern for the public’s welfare culminated in the exclusion of midwives

110. Suarez, *supra* note 104, at 326.

111. STARR, *supra* note 39, at 49. The first documented obstetric practice was set up in 1763, marking physicians’ asserted presence in the area of childbirth. *Id.*

112. Suarez, *supra* note 104, at 326-27.

113. *Id.* at 327.

114. STARR, *supra* note 39, at 223.

115. Stover, *supra* note 10, at 315.

116. Suarez, *supra* note 104, at 326-27; STARR, *supra* note 39, at 59.

117. STARR, *supra* note 39, at 50.

118. Stover, *supra* note 10, at 315.

119. Suarez, *supra* note 104, at 327.

120. *Id.* at 328.

121. An Act to Provide for the Registration of Physicians and Surgeons, MASS. GEN. LAWS ch. 458, § 1 (1894).

122. Tovino, *supra* note 97, at 81, 103.

from licensing protection which would have recognized their profession as a legal practice.¹²³

Underlying doctors' claims of patient safety concerns was their objection to the economic competition midwives posed.¹²⁴ In Alabama, for example, doctors' efforts to eliminate the practice of midwifery did not intensify until midwives began receiving fees for attending childbirths.¹²⁵ Soon after they did, in 1976, the Alabama legislature passed a law making the practice of midwifery illegal,¹²⁶ and as a result, today, there is no legal option for a mother to elect a midwife and home birth.¹²⁷ Similarly, economic competition played an important role in doctors' opposition to midwifery in Massachusetts in the early 1900s, which led to legislative action, culminating in a ban on home deliveries.¹²⁸

Hospital births eventually replaced home births, and obstetricians displaced direct-entry midwives. While approximately half of all births in the U.S. were midwife attended home births in 1900, by 1950 88% of births took place in the hospital, and less than 10% of all deliveries were attended by midwives.¹²⁹ Nurse-midwives became a growing presence in the area of obstetrics during the 1930s as the doctor's subordinate.¹³⁰ However, these professionals offered services to assist doctors and their practice was limited by requiring physician supervision.¹³¹ The holistic approach of direct-entry midwives was abandoned as direct-entry midwives were displaced.¹³²

In addition to childbirth transitioning to the hospital setting, the fundamental protocols of obstetrics also transformed the nature of childbirth as doctors, continued to seek improving obstetrician standing within the medical profession.¹³³ From a philosophy of responding to problems that might present in the process of childbirth, obstetrics evolved to a procedure that sought to prevent potential problems through physician involvement.¹³⁴ Episiotomies and cesareans transformed labor into a surgical procedure,¹³⁵

123. *Id.* at 104.

124. *Id.* at 101.

125. *Id.* at 75.

126. ALA. CODE § 34-19-3 (1976).

127. Tovino, *supra* note 97, at 77-78.

128. *Id.* at 102; *See generally* MASS. GEN. LAWS ch. 112, § 80C (2012).

129. Tovino, *supra* note 97, at 67.

130. *See* STARR, *supra* note 39, at 223.

131. Suarez, *supra* note 104, at 323.

132. *Id.* at 328.

133. *See* Stover, *supra* note 10, at 315.

134. *Id.*

135. Bridget Richardson, *The Regulation of Midwifery*, 8 GEO. J.L. & PUB. POL'Y 489, 492 (2010).

and medical preventive measures became the norm.¹³⁶ Drugs that reduced pain during childbirth and induced labor were increasingly administered unnecessarily and at the risk of harm to the mother and baby.¹³⁷ Pregnancy came to be viewed as a “condition” with “symptoms” external to the mother.¹³⁸ The dramatic transition to the professionalization of childbirth has been explained as

allopathic physicians . . . have enticed ninety-nine percent of us into their places of business (hospitals) for childbirth, forced on us a medical model of birth that has never been proven safe or beneficial, raised the price of services which have diminished in quality and quantity, and lobbied state legislatures for laws that would require [women] to submit to their exclusive control during pregnancy and childbirth.¹³⁹

B. *Re-emerging Midwives & Expanding Patient Scope of Care*

In the 1970s, a general growing distrust of doctors became particularly prominent in the feminist movement as women sought an expanded scope of care to meet their unique needs.¹⁴⁰ Arguing that medicine was sexist and had purposefully excluded women, feminists took a proactive role and sought an active presence within the profession to change the attitude toward and treatment of women from inside the system.¹⁴¹ Women sought to demystify medical care and reverse the medicalization of their lives.¹⁴² In 1973, the Supreme Court legalized abortion in *Roe v. Wade*,¹⁴³ and by the end of the 1970s, women composed 25% of medical students (up from 9% in 1970).¹⁴⁴

This new perspective on medicine and women’s health led women to demand the revitalization of direct-entry midwifery.¹⁴⁵ Joining women in their campaign was the therapeutic counterculture that sought holistic medicine as a better alternative to the “technical, disease-oriented, impersonal” nature of the existing medical system.¹⁴⁶ Advocates of renewing midwifery argued that childbirth was not a disease and required neither hospitalization nor obstetric medical intervention.¹⁴⁷ The grassroots movement was

136. Stover, *supra* note 10, at 315.

137. Suarez, *supra* note 104, at 339-40.

138. *Id.* at 336.

139. *Id.* at 315.

140. STARR, *supra* note 39, at 391.

141. *Id.*

142. *Id.*

143. *Roe v. Wade*, 410 U.S. 113, 166 (1973).

144. STARR, *supra* note 39, at 391.

145. *Id.*

146. *Id.* at 392.

147. *Id.* at 391-92.

premised on the desire for natural and prepared childbirth as an alternative to the overly medicalized hospital procedure that exclusively controlled childbirth.¹⁴⁸ The common ground of the movement was a desire to have the option of a home birth that could offer personalized, supportive care.¹⁴⁹ The American College of Obstetricians and Gynecologists countered such demand for alternative delivery options by claiming that lay midwifery was “unconscionably risky,”¹⁵⁰ and doctors who formed collaborative relationships with midwives were threatened with losing hospital privileges.¹⁵¹

The continuous and growing interest by women for the option of a more traditional process of childbirth¹⁵² has become organized and has earned legislative decision-makers’ attention.¹⁵³ Since the 1970s, the grassroots movement has gradually formed professional organizations that are backed with money to obtain a political voice on behalf of the public.¹⁵⁴ The organizations interject the voice of women who are directly impacted by obstetrician licensure and scope of practice laws and articulate a preference for a more natural approach to childbirth assuming no medical complications exist.¹⁵⁵ In 1994, in response to the inconsistent regulation of direct-entry midwives among states, professional associations of direct-entry midwives created a national education and certification agency, the North American Registry of Midwives, to certify professional midwives.¹⁵⁶ Its goal was to standardize licensure and scope of practice requirements so states could confidently re-introduce direct-entry midwives into the scope of care available to women.¹⁵⁷ In response to this social discourse, birthing centers across the country have opened, and hospitals are modifying their overly medical approach to obstetrics.¹⁵⁸

In Missouri, the law has come to recognize the public demand for alternatives to the dominant childbirth procedure as a legitimate policy interest.¹⁵⁹ In 2007, Missouri passed a bill that included a provision that

148. Stover, *supra* note 10, at 316-17.

149. *Id.* at 317.

150. STARR, *supra* note 39, at 392.

151. *Id.*

152. Stover, *supra* note 10, at 308.

153. *Id.* at 309.

154. *Id.* at 317.

155. *See id.* at 308-09.

156. *Id.* at 318.

157. Stover, *supra* note 10, at 318.

158. *Id.* at 308.

159. *Id.* at 309; *Current Legislative Events, MO. MIDWIVES ASS’N* (2006), <http://www.missourimidwivesassociation.org/legislative.html>. As of 2011, only nine states still prohibited midwifery by law. *Id.*

"notwithstanding any law to the contrary, [allows] anyone who holds current a ministerial or tocolological¹⁶⁰ certification by an organization accredited by the National Organization for Competency Assurance"¹⁶¹ to provide "services related to pregnancy (including prenatal, delivery, and post partum services)."¹⁶² The law answered the demand of Missouri mothers for an expanded scope of care during delivery.¹⁶³ Although doctors protested the bill by asserting "'babies should be delivered in hospitals . . . [as] the safest and best practice,'"¹⁶⁴ the bill passed both houses and was signed into law.¹⁶⁵ That same year, doctors filed suit in state court to challenge the constitutionality of the provision.¹⁶⁶ The circuit court issued a final judgment holding the provision unconstitutional under Article III, sections 21 and 23 of the Missouri Constitution.¹⁶⁷

On appeal, the Missouri Supreme Court overturned the final judgment.¹⁶⁸ Marking a departure from the typical deference usually afforded to the professionals' perspective, the court found that the plaintiff doctors lacked standing to challenge the provision because they had no legally protectable interests at stake.¹⁶⁹ The plaintiff doctors testified that because the practice of medicine includes the provision of pregnancy-related services, coordinating care with lay midwives who are not licensed to practice medicine would expose them to disciplinary action under the new law.¹⁷⁰ They argued such disciplinary action would have a negative effect on their professional reputations and economic livelihood, thus, constituting a protectable interest.¹⁷¹ The doctors also argued that they had a protectable interest in their patients' safety and that the midwife provision posed a risk to pregnant women who sought the services of these practitioners because they could not provide "the care of a licensed and competent physician."¹⁷² The

160. Tocology is an archaic synonym for obstetrics. THEOPHILUS PARVIN, *THE SCIENCE AND THE ART OF OBSTETRICS* 2 (3d ed. 1895).

161. MO. REV. STAT. § 376.1753 (2011).

162. 42 U.S.C. § 1396r-6(b)(4)(E)(ii)(I) (2012) (defining the services referenced in the Missouri statute).

163. See, e.g., Nichole L. Busdieker & Jessica Wilmes, *Midwife Bill Lacks Legislative Support*, COLUMBIA MISSOURIAN (Jan. 8, 2006), <http://www.columbiamissourian.com/a/87709/midwife-bill-lacks-legislative-support/>.

164. *Id.*

165. *Mo. State Med. Ass'n v. State*, 256 S.W.3d 85, 87 (Mo. 2008) (en banc).

166. *Id.*

167. *Mo. State Med. Ass'n v. State*, No. 07AC-CC00567, 2007 WL 6346842 (Mo. Cir. 2007) [hereinafter *Mo. State Med. Ass'n Trial Order*].

168. *Mo. State Med. Ass'n*, 256 S.W.3d at 89.

169. *Id.* at 86.

170. *Mo. State Med. Ass'n Trial Order*, *supra* note 167, at 11.

171. *Id.*

172. *Id.*

Supreme Court rejected these overly-familiar assertions, indicating a shift in the deferential standard that courts had previously granted to healthcare professionals.¹⁷³ Finding that Section 376.1753 “expressly legalizes the services of certified midwives and does so ‘notwithstanding any law to the contrary,’” the Missouri Supreme Court held the statute overrode any of the disciplinary concerns posited by the plaintiff doctors.¹⁷⁴ The limited deference afforded to doctors suggests that legal decision-makers are starting to recognize and account for the patient’s scope of care perspective.

However, doctors are not yet done fighting. On February 2, 2012, the Missouri State Medical Association circulated a newsletter to inform members that the organization is getting ready to “fight” midwives’ lobbying efforts to establish their own licensing board to manage their practice.¹⁷⁵ The newsletter champions its organized lobbying efforts to defeat the proposal and prevent midwives from threatening the status of the medical profession.¹⁷⁶

Studies explain the increased interest and demand for home birth as an expression of “privacy concerns, comfort and convenience, decreases in medical intervention and exposure to infectious agents, cultural and spiritual interests, and desire to remain in control of the environment and process of care.”¹⁷⁷ Women are interested in exploring their options in childbirth and are seeking alternatives to the current option that pressures women into medical intervention.¹⁷⁸ By licensing both obstetricians and midwives, state legislatures are responding to the public’s demand for a broadened scope of care.¹⁷⁹ The differences in philosophy and attitude toward childbirth between obstetricians and midwives give women the choice in alternative approaches to childbirth.¹⁸⁰

State law is recognizing that in order to realize its goal of improving quality and increasing access, it must consider the patient’s scope of care and allow for various, safe approaches to the process of childbirth. Obstetricians and midwives’ different angles allow for experimentation and multiple points of view from diverse classes of thought.¹⁸¹ The licensure laws that reflect the concern for the patient’s scope of care are better informed by

173. Compare *Dent*, 129 U.S. at 128, with *Missouri State Med. Ass’n.*, 256 S.W.3d at 88. See *supra* Part II.A.

174. *Mo. State Med. Ass’n.*, 256 S.W.3d at 88.

175. *Midwifery Rubik’s Cube*, MO. STATE MED. ASS’N LEGISLATIVE REPORT, Feb. 2, 2012, at 2.

176. *Id.*

177. Richardson, *supra* note 135, at 493.

178. *Id.*

179. See MO. MIDWIVES ASS’N., *supra* note 159.

180. Richardson, *supra* note 135, at 493.

181. *Id.* at 503.

including considerations of nonmedical groups and non-healthcare analysts who experience healthcare from different perspectives.¹⁸² Such insights do not threaten the realm of the physician but rather, represent a legitimate social action.¹⁸³ This additional perspective for the patient's scope of care in the debate over licensure and scope of practice laws results in improved quality, increased access, and a broad patient scope of care that nurtures numerous options for patient treatment.¹⁸⁴

IV. THE CURRENT DEBATE: PSYCHOLOGISTS' PRIVILEGE TO PRESCRIBE

The current scope of practice debate is over whether to expand psychologists' scope of practice to include prescribing psychotropic drugs (RxP). The debate is a back and forth between self-interested actors who frame their arguments in terms of quality, access, and cost.¹⁸⁵ Like the history of midwives, this debate presents itself in terms of public policy considerations but really only considers the perspective of self-interested healthcare professionals.¹⁸⁶ The debate is missing an essential perspective on how state legislative decision-making will affect the scope of care available to mental health patients in the long-term.¹⁸⁷

A. *The Context of the Debate*

The current national debate over RxP involves actors across various disciplines and originated as an inquiry within the psychology profession about its role in prescribing medicine.¹⁸⁸ In 1979, a committee within the American Psychological Association (APA) made benign recommendations relating to psychologists' role in prescribing certain medications that eventually evolved into the APA's platform to extend psychologists the

182. Mirvis, *supra* note 36, at 1346.

183. *Id.*

184. Richardson, *supra* note 135, at 493.

185. See *infra* Part IV.B.

186. See *infra* Part V.

187. See, e.g., Nordal, *supra* note 14; Mamah, *supra* note 16.

188. Jan B.E. Leard-Hansson, *Psychologist-Prescribing Efforts: A Brief History*, PSYCHIATRIC NEWS, Feb. 2, 2001, at 31, 31, available at <http://psychnews.psychiatryonline.org/newsArticle.aspx?articleid=102699>.

authority to prescribe psychotropic drugs.¹⁸⁹ In 1995, the APA Council of Representatives formally articulated its objective of achieving prescription privileges and drafted model legislation.¹⁹⁰ The APA has since advocated on behalf of the cause.¹⁹¹ In the late 1980s, the advocacy movement moved from a national platform to make it a state level issue, where licensure and scope of practice is legally controlled.¹⁹² In 1985, Hawaii became the first state to consider legislation that would have authorized psychologists a limited right to prescribe had it not been defeated by the state senate.¹⁹³ On March 5, 2002, the governor of New Mexico signed House Bill 170 into law, making New Mexico the first state to expand psychologists' scope of practice to include the power to prescribe medication.¹⁹⁴ The law mandates specific additional qualifications that must be met in order for a psychologist to obtain a conditional prescribing certificate.¹⁹⁵ Two years later, on May 6,

189. Hayes et al., *supra* note 13, at 698. The committee recommendations were: "1. BPA [Board of Professional Affairs] should review the contributions psychologists can make in the field of chemotherapeutic interventions; 2. Psychologists' role in the use of controlled substances must first be dictated by consumer interest; and 3. Psychologists should seek routine participation in the use of controlled substances at present by establishing psychobehavioral assessment and compliance procedures to evaluate the efficacy of such substances." *Id.* An APA Ad Hoc Task Force on Psychopharmacology strengthened the previous recommendations to reflect the underlying agenda. *Id.* at 699.

190. Robert J. Resnick & John C. Norcross, *Prescriptive Privileges for Psychologists: Scared to Death?*, 9 *CLINICAL PSYCHOL.: SCI. & PRAC.* 270, 272-73 (2002). In 2009, the APA model legislation for psychologist prescribing privileges required completion of an accredited doctoral program in professional psychology, completion of an organized sequence of a program offering intensive didactic education, sufficient clinical experience to attain competency in psychopharmacological treatment of patients, and passage of an examination. AM. PSYCHOLOGICAL ASS'N COUNCIL OF REPRESENTATIVES, MODEL LEGISLATION FOR PRESCRIPTIVE AUTHORITY 2 (2009), available at <http://www.apa.org/about/policy/rxp-model-act.pdf>.

191. William N. Robiner et al., *Prescriptive Authority for Psychologists: A Looming Health Hazard?*, 9 *CLINICAL PSYCHOL.: SCI. & PRAC.* 231, 238 (2002).

192. Hayes et al., *supra* note 13, at 699.

193. *Id.*; HAW. H.J. Res. 159, 99th Cong. (1985); Ronald E. Fox et. al., *Prescriptive Authority and Psychology: A Status Report*, 64 *AM. PSYCHOL.* 257, 257 (2009).

194. N.M. STAT. ANN. § 61-9-17.1 (West 2012); *New Mexico Governor Signs Nation's Only Psychologist-Prescribing Law*, *PSYCHIATRIC NEWS*, Apr. 5, 2002, at 1, 1, available at <http://psychnews.psychiatryonline.org/newsArticle.aspx?articleid=104459>.

195. The law allows a psychologist to prescribe if he or she has completed a doctoral program in psychology from an accredited institution of higher education; holds a current license to practice psychology; has completed pharmacological training (subject to the approval of the New Mexico State Board of Psychology Examiners and the New Mexico Board of Medical Examiners); has passed a national certification examination (subject to the approval of the New Mexico State Board of Psychology Examiners and the New Mexico Board of Medical Examiners); and has completed at least 450 hours of didactic instruction in seven core areas of science and pharmacology, an 80 hour physician-supervised practicum in clinical assessment and pathophysiology, and at least 400 hours supervised practicum of

2004, Louisiana became the second state to expand psychologists' scope of practice to include prescribing practices through its enactment of House Bill 1426.¹⁹⁶ Louisiana's law allows psychologists, who meet certain additional training and educational requirements, to prescribe drugs in consultation with a patient's primary physician.¹⁹⁷

In 2011 alone, six states considered bills that would establish a similar expanded scope of practice with varying requirements.¹⁹⁸ Defeated efforts reappear time and again,¹⁹⁹ and Missouri has attempted to introduce legislation similar to New Mexico's in 2001,²⁰⁰ 2005,²⁰¹ 2006,²⁰² 2007,²⁰³ 2008,²⁰⁴ and 2009.²⁰⁵ Legislative efforts will likely persist given the organized backing of such efforts,²⁰⁶ the increased emphasis on quality,

treating at least 100 patients (all subject to the approval of the New Mexico State Board of Psychology Examiners and the New Mexico Board of Medical Examiners). N.M. STAT. ANN. § 61-9-17.1(A)(1)-(6). The didactic instruction and practicum must be completed within five years of applying for the conditional prescription certificate. *Id.* § 61-9-17.1(A)(5)-(6). The applicant must also have malpractice insurance in place that is satisfactory to the boards of psychology examiners and medical examiners, and satisfy any other requirements promulgated by the board of psychology examiners to apply to the state board of psychologist examiners for a conditional prescription certificate. *Id.* § 61-9-17.1(A)(6)-(8).

196. LA. REV. STAT. ANN. § 37:1360.55 (2012); *Louisiana Enacts Prescription Privileges Law for Psychologists*, PSYCHCENTRAL (May 6, 2004), <http://psychcentral.com/news/archives/2004-05/apap-lep050604.html>.

197. LA. REV. STAT. ANN. § 37:1360.56. The law allows licensed psychologists who graduate with a post-doctoral master's degree in clinical psychopharmacology and pass a national proficiency exam in psychopharmacology (*Id.* § 37:1360.55) to prescribe in "consultation and collaboration" with patients' primary physicians (*Id.* § 37:1360.56). In addition to the prerequisites, psychologists are required to complete twenty hours of continuing medical education relevant to the practice of medical psychology. *Id.* § 37:1360.65.

198. Carolyne Krupa, *Psychologists Seek Prescribing Rights in 6 States*, AM. MED. NEWS (Mar. 7, 2011), <http://www.ama-assn.org/amednews/2011/03/07/pr120307.htm>; H.R. 2260, 50th Leg., 1st Reg. Sess. (Ariz. 2011); S.B. 1400, 26th Leg., (Haw. 2011); S.B. 272, 62d Leg., Reg. Sess. (Mont. 2011); S.B. 2860, 214th Leg., (N.J. 2011); S.B. 228, 76th Leg. Assemb. (Or. 2011); H.R. 3523, 76th Leg. Assemb. (Or. 2011); S.B. 390, 107th Gen. Assemb., 1st Reg. Sess. (Tenn. 2011).

199. Oregon psychologists are on their fifth attempt to pass such legislation. See, e.g., Amanda Waldroupe, *Psychologists Continue Push for Prescribing Rights*, THE LUND REPORT (May 6, 2011), http://lundreport.org/resource/psychologists_continue_push_for_prescribing_rights?quicktabs_1=0.

200. H.R. 1016, 91st Gen. Assemb., 1st Reg. Sess. (Mo. 2001).

201. H.R. 504, 93d Gen. Assemb., 1st Reg. Sess. (Mo. 2005).

202. S.B. 1128, 93d Gen. Assemb., 2d Reg. Sess. (Mo. 2006).

203. H.R. 350, 94th Gen. Assemb., 1st Reg. Sess. (Mo. 2007).

204. S.B. 917, 94th Gen. Assemb., 2d Reg. Sess. (Mo. 2008).

205. H.R. 536, 95th Gen. Assemb., 1st Reg. Sess. (Mo. 2009).

206. The American Society for the Advancement of Pharmacotherapy (ASAP), a division of the APA, leads the initiative for the achievement of psychologists' prescribing rights. Brent

access, and cost of healthcare,²⁰⁷ and the predicted increase in access issues when the Patient Protection and Affordable Care Act takes effect in 2014.²⁰⁸ Therefore, it is important to understand arguments on both sides of the debate, various influences that shape the debate, and how the dialogue affects legislative decision-making.

B. *The Terms: Quality, Access, and Cost*

Both proponents and opponents of RxP appear to be acting on behalf of the public's best interest by framing their arguments in terms of quality, access, and cost.²⁰⁹ Their policy arguments are presented to the public through the media²¹⁰ and to the legislature to inform state actors' decision-making.²¹¹ The American Society for the Advancement of Pharmacotherapy, a division of the APA, is the spearhead for psychologists' legal authority to prescribe.²¹² The five main reasons asserted in favor of its position are:

- 1) psychologists' education and clinical training better qualify them to diagnose and treat mental illness in comparison with primary care physicians;
- 2) the Department of Defense Psychopharmacology Demonstration Project ("PDP") demonstrated non-physician psychologists can prescribe psychotropic medications safely;
- 3) the recommended post-doctoral training requirements adequately prepare psychologists to

Pollitt, *Fool's Gold: Psychologists Using Disingenuous Reasoning to Misdirect Legislatures into Granting Psychologists Prescriptive Authority*, 29 AM. J.L. & MED. 489, 490 (2003); see also *Many Thanks to APAPO's 2010 RxP Leaders*, APA PRACTICE CENTRAL (Oct. 27, 2010), <http://www.apapracticecentral.org/update/2010/10-27/index.aspx> (follow "Many thanks to APAPO's 2010 RxP leaders" hyperlink).

207. Callahan, *supra* note 5, at 229.

208. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 42 U.S.C.). "The problem is likely to become more acute with an estimated 32 million people expected to gain health insurance under the health-care overhaul law." Michelle Andrews, *Psychologists Seek Authority to Prescribe Psychotropic Medications*, WASH. POST (Mar. 21, 2011), http://www.washingtonpost.com/national/psychologists-seek-authority-to-prescribe-psychotropic-medications-/2011/03/17/ABosOH8_story_1.html.

209. Shaheen E. Lakhan, *Prescribing Privileges for Psychologists: A Public Service or Hazard?*, ONLINE J. HEALTH & ALLIED SCI., Jan.-Mar. 2007, at 2, 4-5 (stating that "the central debate is positioned around the public health impact of prescribing psychologists").

210. See, e.g., Andrews, *supra* note 208; see, e.g., Erica Goode, *Psychologists Get Prescription Pads and Furor Erupts*, N.Y. TIMES, Mar. 26, 2002, at F1, available at <http://www.nytimes.com/2002/03/26/science/psychologists-get-prescription-pads-and-furor-erupts.html?pagewanted=all&src=pm>; Shankar Vedantam, *For Psychiatrists, a Bitter Pill in New Mexico: Law Giving Psychologists Right to Prescribe Medications Spurs a Battle With MDs*, WASH. POST, July 1, 2002, at A1.

211. E. Mario Marquez, *Victory: An Insider's View of New Mexico's Legislative Success*, ASS'N FOR THE ADVANCEMENT OF PSYCHOLOGY ADVANCE, Spring 2002, at 1, 13.

212. Pollitt, *supra* note 206, at 490.

prescribe safely psychotropic medications; 4) this privilege will increase availability of mental healthcare services, especially in rural areas; and 5) this privilege will result in an overall reduction in medical expenses, because patients will visit only one healthcare provider instead of two — one for psychotherapy and one for medication.²¹³

The American Psychiatric Association is the strongest opponent of RxP.²¹⁴ Its arguments center on the notion that effective prescribing of psychotropic drugs requires a requisite education and training psychologists do not have.²¹⁵

Opponents of psychologists' prescribing authority, largely psychiatrists, articulate their position as a concern for patient safety and mental health treatment quality that would result from inadequately trained psychologists prescribing drugs.²¹⁶ They claim that the discrepancy between psychologists' and psychiatrists' educational and training backgrounds will result in suboptimal care that will either not properly treat the illness or lead to an adverse harmful outcome.²¹⁷ Although a limited group of non-physician healthcare providers currently prescribe medications (e.g., nurse practitioners, physician assistants), critics of RxP argue these healthcare providers have a medical background and work closely with physicians; whereas, the majority of psychologists do not.²¹⁸ Opponents lend great weight to the value that complex scientific knowledge provides physicians in prescribing medicine because psychotropic drugs "present more complex drug interactions and adverse effects than any other class of drug"²¹⁹ and 50% of patients taking psychotropic medications are on other prescription drugs.²²⁰ Therefore, prescribers of these types of medication require especially intensive training. Opponents of RxP believe the amount of

213. *Id.* at 490-91.

214. *Id.* at 491.

215. *Id.*

216. James E. Long, Jr., Note, *Power to Prescribe: The Debate over Prescription Privileges for Psychologists and the Legal Issues Implicated*, 29 L. & PSYCHOL. REV. 243, 251 (2005).

217. *Id.* at 251-53.

218. *Id.* at 251. According to a study, only 12% of psychologists majored in physical sciences during their undergraduate; less than half of psychologists had taken biochemistry, microbiology, or pharmacology; less than 70% had taken biology and chemistry, and only 85.4% had taken college-level mathematics. William N. Robiner et al., *Prescriptive Authority for Psychologists: Despite Deficits in Education and Knowledge?*, 10 J. CLINICAL PSYCHOL. MED. SETTINGS 211, 213-14 (2003).

219. Robiner et al., *supra* note 191, at 242-43.

220. Julia Johnson, *Whether States Should Create Prescription Power for Psychologists*, 33 L. & PSYCHOL. REV. 167, 174 (2009). Certain combinations of medicines can cause "convulsions, heart arrhythmia, obesity, diabetes, coma, stroke, and death." *Id.* Opponents, therefore, argue that prescribers need to be educated on more than just psychotropic drugs but have a holistic view in order to avoid adverse outcomes. *Id.*

training suggested in proposed legislation is insufficient to prepare psychologists to prescribe these medications in a safe and satisfactory way²²¹ and that the only way to have sufficient understanding of medicine is to attend medical school or graduate nursing school.²²² Opponents fear that “not knowing what they do not know,” psychologists will expose patients to needless risks²²³ and believe these risks to patients threatens the quality of mental health treatment.²²⁴

Conversely, supporters of RxP argue that expanding psychologists’ scope of practice will improve quality.²²⁵ They posit that psychologists will offer a “one stop shop” for individuals who might not have the time or opportunity to go to both a psychologist and a medical doctor.²²⁶ RxP proponents claim this change will improve patient experience by offering a coherent treatment plan and preventing delays in treatment that often result from having to see two professionals, likely in different locations.²²⁷ Supporters assert that their prescribing psychologists’ approach will combine assessment, psychotherapy, and medication to provide the patient with a more holistic approach to mental health treatment than either psychiatrists or general practitioners do.²²⁸

In addition to improving quality, advocates of RxP posit that expanding psychologists’ scope of practice will increase public access to psychotropic treatments.²²⁹ This prospect of increased availability played an essential role

221. Long, *supra* note 216, at 251-53.

222. Vedantam, *supra* note 210, at A6.

223. Robiner et al., *supra* note 218, at 219.

224. A study comparing academic training and preparation data of psychiatric nurse practitioners, physicians, and pharmacologically trained psychologists showed otherwise. Mark Muse & Robert E. McGrath, *Training Comparison Among Three Professions Prescribing Psychoactive Medications: Psychiatric Nurse Practitioners, Physicians, and Pharmacologically Trained Psychologists*, 66 J. CLINICAL PSYCHOL. 96, 102 (2010). The statistics revealed that in all areas besides didactic instruction in biochemistry and neuroscience, pharmacologically trained psychologists receive more extensive preparation than either physicians or psychiatric nurse practitioners for prescribing psychoactive medication. *Id.* at 101. Additionally, both Louisiana and New Mexico have stated that prescribing psychologists have successfully issued prescriptions without reported adverse effects. FLA. LEGISLATURE, OFFICE OF PROGRAM POLICY ANALYSIS & GOV’T ACCOUNTABILITY, LIMITED EVIDENCE ON OTHER STATES’ EXPERIENCES THAT ALLOWING PSYCHOLOGISTS TO PRESCRIBE PSYCHOTROPIC DRUGS IMPROVES ACCESS TO MENTAL HEALTH SERVICES, NO. 09-26, at 5 (2009).

225. See Johnson, *supra* note 220, at 173.

226. *Id.*

227. Pollitt, *supra* note 206, at 519; Long, *supra* note 216, at 251.

228. Johnson, *supra* note 220, at 173. Primary care physicians currently prescribe more than 60% of psychotropic drugs. Laxhan, *supra* note 209, at 4.

229. Long, *supra* note 216, at 248; see also John M. Grohol, *Psychologists Still Seek Prescription Privileges: No New News*, PSYCH CENTRAL (Mar. 22, 2011), <http://psychcentral.com/blog/archives/2011/03/21/psychologists-still-seek-prescription-privileges-no-new-news/>.

in New Mexico's passage of legislation.²³⁰ Advocates used New Mexico census data showing that 61% of the population lived outside of metropolitan areas while only 24% of psychiatrists practiced in those areas to argue there was a need for more providers in these areas.²³¹ They also argued that RxP legislation would address New Mexico's issue of having a 75% higher suicide rate for people between ages fifteen and twenty-four than the national average.²³² Because 75% of those suicides were committed by untreated individuals, advocates posited RxP would reduce the high rate by increasing providers.²³³ The governor and state legislature considered access to mental health treatment in underserved areas as crucial to passing the law²³⁴ and believed that prescribing psychologists would practice in these underserved areas to mitigate the state's existing issues.²³⁵ Similar arguments echo in other states, as advocates champion that RxP will not only address the lack of availability of mental healthcare,²³⁶ but will also increase availability of primary care physicians.²³⁷

RxP opponents argue that the expanded scope of practice will not realize goals of creating more providers in rural areas and providing care to untreated individuals.²³⁸ Data indicating psychologists are no more likely to practice in underserved rural areas than psychiatrists²³⁹ challenges the assertion that expanded scope of practice would address access issues. Even if psychologists were more likely to live in underserved areas, critics of RxP predict access and lack of treatment issues are not as easily resolved by increasing the number of prescribers as supporters of expanding psychologists' scope of practice hope it to be.²⁴⁰

Opponents believe expanding psychologists' scope of practice does not address many contributing factors to the problem such as the stigma

230. Johnson, *supra* note 220, at 172; John Carroll, *Louisiana Psychologists Start Pioneering Program for Mental Health Drugs*, LA. MED. NEWS (2008), <http://www.louisianamedicalnews.com/louisiana-psychologists-start-pioneering-program-for-mental-health-drugs-cms-151>.

231. Johnson, *supra* note 220, at 172.

232. *Id.*

233. *Id.*

234. Marquez, *supra* note 211, at 12-13.

235. Johnson, *supra* note 220, at 172.

236. Long, *supra* note 216, at 248-49. According to National Institute of Mental Health, 44.3 million Americans suffer from mental illness. Johnson, *supra* note 220, at 174.

237. See Lakhan, *supra* note 209, at 4.

238. Pollitt, *supra* note 206, at 517; Mamah, *supra* note 16, at 9 (asserting that only a limited number of psychologists would qualify for or, indicated an interest in prescribing licensure if available, suggesting the laws would not achieve the objective of increased access).

239. Pollitt, *supra* note 206, at 517.

240. See *id.* at 518.

surrounding mental health that prevents people from seeking treatment; poverty as a barrier to accessing treatment; and mental illness as a problem that requires a case-by-case analysis of what the best course of treatment should include.²⁴¹ Sociological studies reveal the untreated mentally ill residing in rural areas are unlikely to seek prescribing psychologists' services even if they were available because the stigma of mental illness leads patients to use their primary care physician instead of a mental health professional for treatment.²⁴² Further, people in need of mental health treatment residing in urban areas go untreated despite the presence of numerous providers, suggesting the real problem of limited access to mental health treatment and the high rate of untreated mental illness is related to the financial situation of the untreated rather than the number of prescribers available to treat.²⁴³ Thus, legislation granting psychologists prescribing authority will not realize the goal of increased treatment for those currently untreated.²⁴⁴ Instead of granting psychologists the power to prescribe, opponents to proposed legislation posit that the better solution to the mental health access issue is collaborative efforts between psychiatrists and primary care physicians.²⁴⁵ Both professions are medically trained, and primary care physicians are more likely to practice in underserved areas.²⁴⁶

Finally, supporters and opponents debate how expanding psychologists' scope of practice will impact the cost of mental health treatment. RxP proponents believe expanding psychologists' scope of practice to include prescribing drugs will lead to reduced costs to patients for mental health treatment by limiting the number of healthcare providers consulted and charging lower fees than psychiatrists.²⁴⁷ Opponents are skeptical that costs will actually be lower for patients seeing a psychologist for their prescribing needs.²⁴⁸ The costs to psychologists of additional education, foregoing work to receive additional training, and increased premiums in their professional liability insurance²⁴⁹ will likely be reflected in the fees they charge.²⁵⁰

241. *Id.*

242. *Id.*

243. *Id.*

244. Pollitt, *supra* note 206, at 518.

245. Long, *supra* note 216, at 253.

246. *Id.* at 253-54.

247. Pollitt, *supra* note 206, at 519. Supporters of RxP argue that this approach will prevent delays in treatment, which would otherwise be costly both financially and by prolonging medical treatment. *Id.*

248. *Id.*

249. Johnson, *supra* note 220, at 175-76; Long, *supra* note 216, at 256-58. This is especially true if courts decide to hold prescribing psychologists to the standard of care applied to physicians as opposed to the standard of care that would be exercised by a reasonably prudent, similar professional. *Id.* at 256. If the higher standard is applied, patients

C. *Debating Self-Interests*

While on the surface the policy considerations appear to act in the public's best interest, they are posited from the perspectives of biased actors, who have financial and professional self-interests at stake. RxP will affect not only psychologists and psychiatrists' interests,²⁵¹ but also other professional institutions, such as insurance and pharmaceutical companies and educational institutions.²⁵² Advocates and opponents external to either profession are incentivized to become active voices in the debate based on the potential effects the legislation will have on their industries.²⁵³

Within the field of psychology, professionals are split in their position on whether psychologists should have the legal authority to prescribe with each side motivated by the effects such legislation will have on their practice.²⁵⁴ In one survey, only 55% of APA members supported an initiative that would allow appropriately trained psychologists the right to prescribe.²⁵⁵ The strongest supporters of RxP are the practice-based organizations, while scientist-practitioners oppose the legislative efforts.²⁵⁶ This opposition has led to the establishment of the American Association of Applied and Preventive Psychology, the Society for a Science of Clinical Psychology, the Committee Against Medicalizing Psychology, and the Council of University Directors of Clinical Psychology.²⁵⁷ These organizations believe that the APA's commitment to pursuing prescribing authority sacrifices the scientific and disciplinary values of the profession in favor of medical approaches.²⁵⁸ The tension within the profession warns that the arguments dressed in terms of access, quality, and cost are not as beneficent as they appear.²⁵⁹ Additionally, practical considerations of putting their practices on hold to obtain the additional requirements for prescribing influence practicing

are protected from the potentially lower standard for prescribing psychologist that could result in unsafe prescribing; however, that protection comes at a higher cost. *Id.* at 257.

250. Pollitt, *supra* note 206, at 519.

251. Lakhan, *supra* note 209, at 5.

252. *Id.* at 5, 8.

253. *Id.*

254. See, e.g., Elaine M. Heiby & John Winston Bush, *Giving Prescription Privileges to Psychologists Would be a Very Dangerous Experiment. Here are 10 Reasons Why*, SOC'Y FOR THE SCI. OF CLINICAL PSYCHOL. NEWSL., Fall 2002, at 6. In 2002, a survey revealed that approximately "half of psychologists opposed prescriptive authority for psychologists and the APA's efforts to lobby for it." Robiner et al., *supra* note 218, at 216.

255. Hayes et al., *supra* note 13, at 703.

256. *Id.* at 700.

257. *Id.*; Heiby & Bush, *supra* note 254, at 6.

258. See Hayes et al., *supra* note 13, at 700.

259. See Long, *supra* note 216, at 256.

psychologists' opposition.²⁶⁰ On the other hand, students of psychology, young psychologists,²⁶¹ and professional organizations, whose existence is longer lasting, have financial and power-based incentives to obtain the privilege to prescribe.²⁶² Supporters of RxP present the "one stop shop" paradigm as a quality benefit in an effort to push the boundary of psychologists' scope of practice to reach their "final destination" as an independent and autonomous practitioner.²⁶³ With the authority to prescribe medicine, psychologists will be able to receive higher insurance reimbursements for treating patients,²⁶⁴ reflecting an "economically-motivated effort by . . . organized psychology."²⁶⁵

Psychiatrists are influenced by their self-serving desire to protect their control over the practice of medicine. Because the definition of the practice of medicine is broad and overly-inclusive, doctors can modify their practices without having to amend their scope of practice.²⁶⁶ They do not risk the same legal threats and disciplinary potential for evolutions in their practice as other healthcare providers and, therefore, benefit from the status quo.²⁶⁷ Further, doctors are self-regulated, and although barriers to enter the medical profession are high, once licensed, medical doctors essentially hold lifetime licensure.²⁶⁸ Allowing overlap of practice between physicians and other healthcare providers threatens this security, as well as physician autonomy, by opening the door to other professional representation on state professional boards.²⁶⁹ Generally, the American Medical Association dictates physician opposition to legislative efforts for other healthcare professionals' expanded scopes of practice.²⁷⁰ This default opposition undermines the sincerity of psychiatrists' argument against RxP due to their concern for patient safety.²⁷¹

Further, psychiatrists' economic position is threatened if psychologists gain the power to prescribe. Insurance companies are likely to reimburse

260. Hayes et al., *supra* note 13, at 703.

261. Lakhani, *supra* note 209, at 6.

262. Hayes et al., *supra* note 13, at 705.

263. Lakhani, *supra* note 209, at 5.

264. Vedantam, *supra* note 210, at A6.

265. Stephen Barrett, *Why Psychologists Should Not be Licensed to Prescribe Psychiatric Drugs*, QUACKWATCH (Mar. 28, 2008), <http://www.quackwatch.org/07PoliticalActivities/rxp1.html>.

266. Safriet, *supra* note 4, at 308.

267. *See id.*

268. Holcombe, *supra* note 31, at 240-41.

269. *See id.*

270. Safriet, *supra* note 4, at 309.

271. Long, *supra* note 216, at 255-56.

psychologists' work at a lower rate than psychiatrists',²⁷² and psychiatrists will be forced to accept similar lowered payments for their practices. These economic concerns, along with the historic defiance toward any healthcare professional's attempts at expanded scope of practice²⁷³ and their position of power (the exclusive authority to practice medicine),²⁷⁴ could certainly drive psychiatrists' stance, putting the patient second to their own self-interests.²⁷⁵

In addition to the underlying interests of the healthcare professionals, outside self-interested actors are stakeholders in the outcome who infiltrate the debate. Stakeholders include "individual providers' professional groups, institutional providers' professional groups, institutional providers' organizations, employers' associations, insurance and financing federations, specialized consumer advocacy groups, pharmaceutical and medical device manufacturers, and legislative and regulatory entities."²⁷⁶ Independent, for-profit professional schools and continuing education institutions are a major supporter of proposed legislation.²⁷⁷ Elaine LeVine, who has been an active presence in advocating for support of legislative efforts to expand psychologists' scope of practice to include prescribing authority,²⁷⁸ is also a training director at The Southwestern Institute for the Advancement of Psychotherapy.²⁷⁹ Her advocacy for RxP in pursuit of helping people in need and unable to obtain help²⁸⁰ becomes questionable in light of her financial incentive related to her position at the educational institution that stands to profit from such legislation.

Insurance and pharmaceutical companies also have a lot to gain from psychologists obtaining prescribing authority and play an influential role in psychologists' advocacy. With psychologists entering the market of prescribing, insurance companies can reduce payments to psychotropic drug prescribers and increase profits, as discussed above.²⁸¹ Pharmaceutical companies also see RxP state laws as opening a door to a new group of

272. Vedantam, *supra* note 210, at A6.

273. Long, *supra* note 216, at 256.

274. Safriet, *supra* note 4, at 307.

275. *Id.* at 316.

276. *Id.* at 302.

277. Heiby & Bush, *supra* note 254, at 6.

278. Jennifer Daw, *New Mexico Becomes First State to Gain Rx Privileges*, MONITOR ON PSYCHOL., Apr. 2002, at 24, available at <http://www.apa.org/monitor/apr02/newmexico.aspx>.

279. N.M. STATE UNIV., SW. INST. FOR THE ADVANCEMENT OF PSYCHOTHERAPY, AN INTERDISCIPLINARY MASTERS OF ARTS IN PSYCHOPHARMACOLOGY FOR PSYCHOLOGISTS: FACULTY HANDBOOK 11 (2010).

280. Daw, *supra* note 278.

281. See Pollitt, *supra* note 206, at 523.

marketable providers.²⁸² Antidepressant medications were the third highest ranked pharmaceutical sold worldwide, and antipsychotic medications earned \$6.5 billion dollars in 2004.²⁸³ Pharmaceuticals' vested business interests overlook the important policy considerations that should be central to the debate, namely the public's best interest.²⁸⁴

Although both sides of the debate present legitimate policy reasons for passing or defeating legislative efforts to expand psychologists' scope of practice, the perspectives that either side considers in formulating its arguments are limited and dictated by financial and professional interests at stake.²⁸⁵ It boils down to a turf war²⁸⁶ between professions for power and status²⁸⁷ at the expense of broader considerations for the patients' personal interests.²⁸⁸ The self-interested actors present legislative decision-makers with an incomplete picture. What seems to be missing from the debate is the same perspective that was missing when obstetricians took over the practice of childbirth: the perspective considering the long-term effects on the patient's scope of care.²⁸⁹ The absence of the perspective for the public inhibits realization of the ultimate public policy goal of protecting the public welfare.

V. APPLYING INSIGHTS FROM THE PAST

The long-term effects of authorizing psychologists to prescribe psychotropic drugs (RxP) will result in a narrowed patient scope of care, and hence, will undermine the needs of the very patients these debates are purported to serve. The consequences of excluding midwives from licensure and scope of practice laws suggest that the current scope of practice debate regarding RxP will not achieve the ultimate goals of protecting public welfare.²⁹⁰ Rather, expanding psychologists' scope of practice to include prescribing authority will diminish varied models of mental health treatment as current approaches converge to limit the spectrum of treatment options available to mental health patients and ultimately narrow the patient's scope of care.²⁹¹ Applying relevant lessons from the history of midwifery suggests

282. Lakhan, *supra* note 209, at 5.

283. Steven S. Sharfstein, *Big Pharma and American Psychiatry: The Good, the Bad, and the Ugly*, 40 PSYCHIATRIC NEWS, Aug. 19, 2005, at 3, 3, available at <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=109213>.

284. See Lakhan, *supra* note 209, at 5.

285. See Vedantam, *supra* note 210, at A6.

286. Callahan, *supra* note 5, at 218.

287. *Id.* at 224.

288. Vedantam, *supra* note 210, at A6.

289. See *supra* Part III.

290. See *supra* Part III.

291. See *infra* Part V.A-B.

that reduced scope of care is not in the patient's best interest and will eventually result in a public demand to return to a broader scope of care. Considering the long-term effects of RxP on patient scope of care during state legislative decision-making can prevent erosion of effective treatment options and potential public health problems and future public backlash.

A. *Implications of Granting Psychologists the Authority to Prescribe*

Psychology offers a different approach to mental illness than psychiatry and its methodology allows psychologists to effectively treat patients without medical intervention. Since its origins, psychology has evolved as a distinct discipline from psychiatry.²⁹² In 1896, Lightner Witmer introduced the term "psychology" to the mental health field as a profession that would collaborate with physicians in the clinical environment.²⁹³ He believed psychology was an academic discipline distinct from medicine.²⁹⁴ After World War II, the demand and financial incentives to provide mental health services pushed psychology towards a "scientist-practitioner" model of practice.²⁹⁵ By the 1950s, psychologists redefined themselves as psychotherapists and rejected the biomedical disease model of mental illness in order to remain distinct from psychiatry.²⁹⁶ Although psychology has undergone change over time, psychologists have always offered services that are distinguishable from those of prescribing psychiatrists and have offered a different approach to mental illness.²⁹⁷

The fundamental difference between psychology and psychiatry lays in the graduate educational training for each profession. Psychologists' orientation is behavioral while psychiatrists' is medical.²⁹⁸ Psychologists' scientific training is in the areas of behavioral and social sciences while psychiatrists' training is in the medical sciences.²⁹⁹ Ph.D. programs in psychology focus on clinical research issues and counseling skills to diagnose and treat mental disorders.³⁰⁰ Clinical psychology programs include psychopharmacology, neuroanatomy, and physiology classes but do not include the foundational, advanced science, and biomedical coursework of medical school and psychiatric specialization.³⁰¹ The focus of

292. See Lkhan, *supra* note 209, at 2.

293. *Id.*

294. *Id.* at 2-3.

295. *Id.* at 3.

296. *Id.*

297. See Pollitt, *supra* note 206, at 494 n.45.

298. Phyllis Coleman & Ronald A. Shellow, *Extending Physician's Standard of Care to Non-Physician Prescribers: The Rx for Protecting Patients*, 35 IDAHO L. REV. 37, 70 (1998).

299. Heiby & Bush, *supra* note 254, at 6.

300. Pollitt, *supra* note 206, at 503.

301. *Id.*

psychological training is on scientific knowledge at the psychological level of analysis in order to better understand and reduce human suffering.³⁰² Applying their knowledge to help patients cope with psychological distress,³⁰³ psychologists offer a “unique contribution” to clinical work in the forms of assessment, behavioral programming, analysis, and psychotherapy that is distinct from psychiatrists’ approach which has a medical foundation.³⁰⁴ Psychologists may avoid psychotropic drugs because they believe pills simply permit patients to avoid their emotional pain rather than develop the skills necessary to deal with life’s problems, which they believe is the ultimate goal of psychotherapy.³⁰⁵

Predictions regarding the long-term effects of RxP suggest that a fundamental change in the educational training of psychologists will be required to realize the vision of psychologists obtaining prescribing licensure. The minimal amount of additional training needed for psychologists to be able to prescribe is equivalent to two years of coursework.³⁰⁶ Under New Mexico’s Professional Psychologist Act, psychologists must obtain an additional 450 hours of didactic instruction in seven core areas of science and pharmacology,³⁰⁷ and under Louisiana’s statute, psychologists are required to complete two additional curriculum concentration areas in anatomy and biochemistry.³⁰⁸ It is likely that this additional psychotropic training will become part of psychology doctoral training in an effort to reduce the amount of time in school and to encourage all psychologists to obtain prescribing status.³⁰⁹ If the additional training were to remain post-doctoral, the duration of training would be similar to psychiatry, frustrating cost control goals.³¹⁰ Further, this additional time may deter professionals from pursuing this option.³¹¹ As responsibility and influence in academia transfers to future generations of prescribing psychologists,³¹² the consequence of prescription privilege training will be a “cannibalization of the existing psychology practice base.”³¹³ Doctoral

302. Hayes et al., *supra* note 13, at 701.

303. Lakhan, *supra* note 209, at 9.

304. John Winston Bush, *Professional Issues: SSCP Task Force Statement on Prescribing Privileges (RxP)*, SOC’Y FOR THE SCI. OF CLINICAL PSYCHOL. NEWSL., Winter 2001, at 7.

305. Vedantam, *supra* note 210, at A6.

306. Johnson, *supra* note 220, at 171.

307. N.M. STAT. ANN. § 61-9-17.1 (West 2012).

308. LA. REV. STAT. ANN. § 37:1360.55 (2012).

309. See Muse & McGrath, *supra* note 224, at 102.

310. See, e.g., N.M. STATE UNIV., SW. INST. FOR THE ADVANCEMENT OF PSYCHOTHERAPY, *supra* note 279, at 44-53.

311. Hayes et al., *supra* note 13, at 703.

312. Lakhan, *supra* note 209, at 6.

313. Hayes et al., *supra* note 13, at 704.

programs will have to restructure their traditional coursework requirements to include pharmacological training, which will displace and diminish the basic psychological training at the graduate level.³¹⁴ Eventually, the prescribing authority gained will be at “the expense of the broader areas in which psychologists contribute knowledge.”³¹⁵ Curriculum changes in the doctoral education will inevitably change skill sets, as well as the type of people attracted to and selected into the profession,³¹⁶ and sacrifice the fundamental nature of the profession.³¹⁷

This fundamental change in training at the graduate level will result in a fundamental change in the profession of psychology at a practical level and as a whole. Indeed, the American Association of Applied and Preventive Psychology, along with other groups,³¹⁸ opposes legislative efforts to give psychologists the power to prescribe out of concern that this change in practice will result in a fundamental change in the discipline.³¹⁹ Professional pressure will push psychologists entering the field towards prescribing licensure. Although some psychologists hold they will not pursue the prescription privilege if it were available, consumers will undoubtedly have a hard time distinguishing between different types of psychologists, resulting in confusion.³²⁰ To combat the confusion, professional organizations will strive to create a more homogeneous profession, which will redefine psychology.³²¹ There will be pressure on psychologists to retrain to meet the new patient expectations, morphing the current profession into a new discipline.³²² Prescribing psychologists will supplant non-prescribing psychologists by creating a “new breed” of psychologist that will wield power and change their presence in the healthcare field.³²³ The focus on prescribing will distance psychology from its traditional biopsychosocial model of mental health by advancing a bio-bio-bio model, which more closely resembles psychiatry.³²⁴

Not only will the discipline of psychology fundamentally change, but scope of practice laws enabling psychologists to prescribe will also have an effect on the quality of and access to various mental health treatments as a whole. The executive director of the Global Neuroscience Initiative

314. Bush, *supra* note 304, at 9; Lakhan, *supra* note 209, at 7.

315. Bush, *supra* note 304, at 7.

316. See Lakhan, *supra* note 209, at 8.

317. See *id.* at 9.

318. Heiby & Bush, *supra* note 254, at 6.

319. Hayes et al., *supra* note 13, at 700-01.

320. *Id.* at 703-04.

321. *Id.* at 704.

322. Pollitt, *supra* note 206, at 521.

323. *Id.*

324. Lakhan, *supra* note 209, at 9.

Foundation believes that “the difference between psychologists and psychiatrists — at least how most of the public perceives it — may soon disappear.”³²⁵ Insurance companies will opt to cover psychologists, at the expense of psychiatrists, eventually driving them out of practice.³²⁶ Accepting lower reimbursements from managed care organizations than those now provided to psychiatrists, psychologists will replace psychiatrists as less medically trained drug prescribers.³²⁷ Current mental health models will converge into one approach that resembles what psychiatry (predominantly pharmacological treatment) is today, but perhaps at a lower standard of expertise since psychologists will not be required to attend medical school.³²⁸ Further, the prescribing psychologist will not understand the patient as completely as a physician³²⁹ and will not be sufficiently trained to understand medical complications that may manifest.³³⁰ The effect of these changes will reduce the array of approaches that currently exist to treat mental illness.³³¹ To abandon this approach in pursuit of a more medical approach will result in the elimination of an important perspective to a multifaceted problem. For example, psychological researchers study various psychosocial factors such as family dysfunction, poverty, urban living, racism, and child abuse as causal agents of psychosis as opposed to triggers or exacerbations of mental illness.³³² Threatening access to this approach to mental health treatment as psychologists move towards a better financially reimbursed medical approach diminishes quality and variety of treatment methods.

B. *Scope of Care Should Influence Legislative Decision-Making*

Drawing on lessons from the history of midwifery should inform legal decision-making to include the patient’s scope of care as a factor in the debate regarding RxP.³³³ Without considering patient scope of care, state

325. *Id.* at 1-2.

326. Pollitt, *supra* note 209, at 523.

327. *Id.* at 521; Vedantam, *supra* note 210, at 3.

328. See Vedantam, *supra* note 210, at A6 (discussing the Department of Defense program that trained ten psychologists to prescribe and although they filled critical needs, psychologists and psychiatrists were in “unanimous agreement that the graduates were weaker medically than psychiatrists.”).

329. *Id.*

330. See Coleman & Shellow, *supra* note 298, at 70. In an interview, Dr. Paul Applebaum cited the example of a recently discovered side effect of liver toxicity for a mood stabilizer medication. Vedantam, *supra* note 210, at A6. He said, “Any physician who gets that letter has a framework to fit that information . . . [p]sychologists have none of that.” *Id.*

331. See Bush, *supra* note 304, at 9.

332. John Read, *The Bio-Bio-Bio Model of Madness*, 18 *PSYCHOLOGIST* 596, 597 (2005).

333. See *supra* Part III.

legislatures will fail to realize the ultimate healthcare policy goals of state licensure and scope of practice laws (quality, access, cost). Even if RxP were to increase availability of mental health treatment providers, the overall medicalization of the specialty will diminish effective psychological treatments, and psychiatric models sacrifice quality of and limit access to the treatment options currently available. Obstetricians' medicalization and professionalization of child delivery eliminated access to direct-entry midwives and resulted in reduced quality of care afforded to the individual woman. Obstetricians displaced the holistic philosophy followed by midwives with their sterile approach.³³⁴ Similarly, the hybrid psychologist will displace the psychiatrist as a cheaper alternative prescriber and result in decreased access to psychiatrists (as doctors will be less inclined to pursue that specialty) and the traditional psychologist whose identity was distinct from a psychiatrist's. The overall consequence will be an abandonment of the valuable treatment methodologies each profession offers and a narrowed scope of care for patients.

Just as obstetricians framed the licensure and scope of practice debate over delivery from their professional perspective to raise their professional status within the medical community, psychologists seek RxP to leverage their position within the mental health treatment professional community. Framing the issue from professional perspectives reduces the debate to the line pushing that scope of practice law enables. As critics of licensure laws have warned,³³⁵ and as the history of midwifery demonstrates,³³⁶ this approach places too much emphasis on professionals' perspectives at the expense of the public. The history of midwifery teaches us that ignoring the patient's scope of care in scope of practice debates eventually results in a public demand for choice in treatment to fit her individualized circumstance.³³⁷

Analyzing and understanding how RxP will affect the access to, models of, and quality of mental healthcare offered to the patient is key to realizing the healthcare policy goals that state licensure and scope of practice law seek to accomplish.³³⁸ Psychologists' "one-stop shop" vision neglects consideration of how this fundamental change threatens psychiatry's existence and psychology's identity.³³⁹ Currently, both sides of the debate address access concerns in terms of whether proposed scope of practice legislation will actually increase the availability of psychotropic drugs to

334. Stover, *supra* note 10, at 315, 320.

335. Safriet, *supra* note 4, at 302.

336. See *supra* Part III.

337. See *id.*

338. Callahan, *supra* note 5, at 218-19; Safriet, *supra* note 4, at 304.

339. Johnson, *supra* note 220, at 173; Pollitt, *supra* note 206 at 521.

untreated mental health populations.³⁴⁰ Neither considers how RxP will affect access in terms of the availability of varied treatment options to the patient in the long-term. Current cost control analysis is limited to considering whether or not psychologists will charge lower fees.³⁴¹ It omits how those lower fees will impact access to and quality of both psychology and psychiatry as varied professional options available to the patient.³⁴²

When the patient's scope of care is factored into the debate, state decision-makers will find the long-term effects of RxP will be narrowed and patient scope of care quality lowered. Current mental health treatment options (talk therapy, medicine, or a combination) are likely to be replaced by a lower quality treatment approach in which psychologists do it all, despite not possessing the robust medical educational background of psychiatrists and sacrificing several fundamental training components of their discipline.³⁴³ The "one-stop shop" vision championed by advocates of psychologists' prescribing authority as a way to improve quality and control costs will limit overall options available to patients seeking mental health treatment to a profession that lacks an identity.³⁴⁴ This echoes how the doctors' concern for the mother's safety ultimately displaced the holistic approach that midwives provided to women who preferred or were better served individually by that option.³⁴⁵ Instead of offering their practice as an alternative approach to childbirth, obstetricians replaced the midwives' philosophy with a uniform model that characterized pregnancy as a medical condition.³⁴⁶ Catering to obstetrician self-interests and advancing a one-procedure-fits-all model proved to be near-sighted at the expense of the patient.³⁴⁷ Similarly, if legislative efforts succeed in extending prescribing authority to psychologists, psychologists will replace the several models of mental health treatment that currently exist³⁴⁸ and erode psychiatric services. Acting to advance their self-interested motives, supporters of RxP threaten patient scope of care, the protection of which healthcare policy decision-making seeks to serve.

340. See e.g., Marquez, *supra* note 211, at 13 (arguing that the proposed regulations will expand access). *But see* Pollitt, *supra* note 206, at 505-06 (discussing the issues of rural areas lacking access to psychotherapy as well as the fact that the main issue is satisfactory education, not increasing access to prescription drugs).

341. Pollitt, *supra* note 206, at 519-20.

342. Pollitt, *supra* note 206, at 519-20; see, e.g., Nordal, *supra* note 14, at 1.

343. Lakhan, *supra* note 209, at 8-9.

344. Pollitt, *supra* note 206, at 493-94.

345. See *supra* Part III.

346. Suarez, *supra* note 104, at 335-36.

347. See *supra* Part III.B.

348. Lakhan, *supra* note 209, at 3.

State decision-makers should no longer allow healthcare professionals to define the issue exclusively as “*can* psychologists safely prescribe” but should expand the debate to ask: “*should* psychologists prescribe in ways to advance scope of care.” Limiting the consideration to professional ability only, the debate feeds into the notion of a “quick fix” that psychotropic drugs can provide and reduces the emphasis placed on psychotherapy and psychosocial treatment.³⁴⁹ Quality treatment is not preserved simply because medical doctors will possess prescribing medicine as their exclusive turf. Rather, quality is maintained because both models of mental health treatment will be able to coexist without one winning as superior quality to the other. Many psychiatrists and psychologists currently suggest the best treatment for mental illness requires a combination of medicine and talk therapy or a trial of one after the other.³⁵⁰ Denying psychologists the authority to prescribe validates psychology’s methodology and allows patients to pursue whichever approach is best suited for them. This broad scope of care afforded to the patient will ensure a quality of and access to treatment that went missing when obstetricians successfully defined quality for childbirth as existing within a hospital’s walls.

VI. AVOIDING MYOPIA IN PATIENT SCOPE OF CARE

The concept of patient scope of care that I derived from an historical analysis of midwifery in the United States³⁵¹ is critical to shaping and understanding the current licensure and scope of practice debate concerning whether psychologists should be authorized to prescribe psychotropic drugs. When consideration of patient scope of care is added as a factor in deliberations by state legislatures, it becomes evident that RxP may not produce an outcome that is in the public’s best interest. State actors must depart from the current approach to healthcare professionals’ licensure and scope of practice laws that limit the debate to professionals’ perspectives and defers to their medical autonomy.³⁵² Legislators must include in their analysis a perspective and concern for the mental health patient’s scope of care and the value patients place in a broad variety of treatment options. By interjecting scope of care into the debate now, policy decision-makers can avoid a future public backlash that will demand a higher quality, more accessible, and more complete approach to mental health treatment. It will also diffuse the territorial battle between professions that has evolved over the historical course of licensure and scope of practice laws through legal recognition and appreciation for the value that patients

349. Sharfstein, *supra* note 283.

350. *Id.*

351. See *supra* Part III.

352. Safriet, *supra* note 4, at 304.

attribute to each profession's unique contribution to mental health treatment.

As demonstrated by the history of direct-entry midwives' scope of practice, different patients prefer different approaches to pregnancy and child delivery. Passing laws that favored one practitioner's model over another was short-sighted and resulted in over-medicalization of childbirth and the unavailability of methodologies that some patients desired. By adding an element to the debate that considers the long-term effects on the patient's scope of care, legal decision makers have a more robust framework in which to consider licensure and scope of practice laws. Policy makers can realize that extending the right to prescribe to psychologists is not in the best interest of healthcare public policy goals to protect the public's welfare. Enlightened policy will support a variety of models of treating mental health to provide the best patient outcome.

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