# The Physician's Assistant and the Problem of Statutory Authorization

## I. INTRODUCTION

A well-documented shortage of medical doctors exists in the United States,[1] and the problem is likely to be long-term.[2] Until the number of doctors in America increases dramatically, it will be incumbent on the medical profession to use its available manpower with an ever-greater level of efficiency. One of the more promising responses to the doctor shortage has been the development through state legislation of a new category of health worker: the "physician's assistant."[3]

The physician's assistant is a specially trained worker whose function is to perform medical tasks formerly done by the physician, thereby freeing the latter for work more appropriately geared to his superior skill and training. The American Medical Association defines the physician's assistant as a "skilled person qualified by academic and practical on-the-job training to provide services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."[4] Trained in special programs that

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[1]In 1970, there were 310,845 professionally active M.D.'s in the United States, or 153 per 100,000 population. Since 1950, the total number of professionally active physicians has increased by nearly 100,000, but the proportion of active M.D.'s actually treating patients in office-based practice has been decreasing in recent years. This figure has gone from 103 per 100,000 population in 1950 to 90 in 1969. More and more physicians are going into hospital-based practice or for areas of professional activity other than patient care, such as research. Therefore, the number of M.D.'s in private practice has declined, although physician-population ratios have increased. A national shortage of one million health workers is predicted for 1975. *See* California Medical Association, *Physician's Assistants — A Socio-Economic Report of the Bureau of Research and Planning*, 112 CALIF. MED. 73 (1970).

[2]A substantial increase in the number of doctors is not likely to occur in the immediate future because of the cost and time involved in this training. Also, the number of medical schools is not increasing at a rate that would rapidly accelerate the number of doctors; even should such an increase take place, the length of time involved in medical education would prevent a corresponding increase of physicians for several years.

[3]Hereinafter the name "physician's assistant" will be used interchangeably with the initials "PA".

[4]Recommended by the American Medical Association's Board of Trustees and its

range in length anywhere from four months to five years,[5] the PA serves to bridge the professional gap which separates the physician and the purely technical health care worker. To the extent dictated by his level of training, the PA's position may involve a range of independence varying from closely supervised work to the exercise of individual medical judgment.

Recognition of the PA concept has been manifested recently on a number of different fronts. Since the Duke University Medical Center inaugurated its training program for physician's assistants in 1965,[6] a growing number of states have enacted PA legislation and established PA training programs. By the end of 1972, legislation pertaining to physician's assistants had been enacted in twenty-four states.[7] The federal government has made a major commitment to the training of PAs. Congress enacted legislation in 1971 to finance

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Council on Health Manpower as the working definition of the "physician's assistant".

[5]Some examples of these varied programs are:

(1) The University of Washington's Medex program was founded in 1969 for the returning military corpsman who possesses extensive medical training and independent duty experience. The program includes three months of university-based education followed by twelve months of preceptorship with a practicing physician. The objective is to fit each Medex to a particular physician's practice. Emphasis is placed on primary care practice in rural areas.

(2) A four-month "health assistants" training program is sponsored by Project Hope in Laredo, Texas (1970). The only requirement for entry is that the student be eighteen years of age.

(3) The Orthopedic Assistant (1960) and Urologic Physician's Assistant (1970) are two-year programs designed to train personnel to work directly for specialists.

(4) The Child Health Associate Program (1969) prepares individuals to "practice pediatrics" under close physician supervision as defined under a Colorado law. Students are admitted after two years of college for a three-year sequence of professional studies, which includes a year of intership. A baccalaureate degree is awarded.

These program summaries were taken from A. SADLER, B. SADLER & A. BLISS, THE PHYSICIAN'S ASSISTANT—TODAY AND TOMORROW 20-22 (1972) [hereinafter cited as SADLER, SADLER & BLISS].

[6]*Id.* at 33.

[7]CODE OF ALA. tit. 46, §§ 297(22jj)-(22nn) (Supp. 1971); ALAS. STAT. BUS. & PROF. §8.64.170 (1973); ARIZ. REV. ANN. § 32-1421(9) (Supp. 1973); ARK. STAT. 1947 ANN. §72-604(p) (Supp. 1973); CAL. BUS. & PROF. CODE §§ 2510-2522 (West Supp. 1974); COLO. REV. STAT. ANN. §§ 91-10-1 to -15 (Supp. 1969) and §91-1-6 (1964); CONN. GEN'L. STAT. ANN. § 20-9 (Supp. 1973); DEL. CODE ANN. tit. 24, §1731(d)(6) (Supp. 1972); FLA. STAT. ANN. §458.135 (Supp. 1974); CODE OF GA. ANN. §§ 84-6201 to -6209 (Supp. 1973); IDAHO CODE § 54-1806(d) (Supp. 1973); IOWA CODE ANN. §§ 148 B.1-B.10 (1972); KAN. STAT. ANN. § 65-2896 (Supp. 1973); MD. CODE ANN. § 119, art. 43 (1971); REV. CODES OF MONT. 1947 § 66-1012 (L) (1970); N.H. REV. STAT. ANN. § 329:21 XII-XIII (Supp. 1973); N.Y. PUB. HLTH. LAW §§ 3700-3702 (McKinney's Supp. 1973); GEN'L. STAT. OF N.C. § 90-18 (Supp. 1973); OKLA. STAT. ANN. tit. 59, §492 (1971); ORE. REV. STAT. § 677.065 (1973); UTAH CODE ANN. § 58-12-40 (Supp. 1973); VT. STAT. ANN. §§ 26-1725 to -1729 (Supp. 1973); REV. CODE OF WASH. ANN. tit. 18, §§71A.010-.060 (Supp. 1974); W. VA. CODE ANN. §§ 30-3A-1 to -4 (1971).

PA training, and funding for the PA programs was combined in a new office of Special Programs, Bureau of Health Manpower Education of the National Institute of Health.[8] The American Medical Association has developed "Essentials for an Approved Educational Program for the Assistant to the Primary Care Physician."[9] Since the completion of these essentials in 1971, the AMA has moved rapidly in accreditation of PA programs. The National Board of Medical Examiners has established a special committee on the certification of the physician's assistant. This committee has been working to develop a national certifying examination to bring more unity to the varied types of PA training and education programs that are being developed throughout the country.[10]

The thesis of this article is that the successful integration of the PA into the medical profession depends to a vital extent upon the adoption of intelligent and creative legislation by the various states. The article will: (1) discuss the need for and potential objectives of PA legislation; (2) describe the various approaches taken by states which have already enacted such legislation, and (3) recommend specific solutions to the problems of statutory authorization.

## II. LEGISLATION AUTHORIZING THE PHYSICIAN'S ASSISTANT

The legal status of the PA depends on state legislation providing authorization for him to practice. The present structure of medical laws in the United States neither includes nor permits a category of medical workers which, by training or responsibility, falls between that of the licensed physician and the nurse or technician.[11]

### A. THE NEED FOR LEGISLATIVE SANCTION

Medical practice laws originated when there were few health manpower categories. The statutes were phrased to authorize qualifying physicians to perform all health care functions. The conditions under

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[8]During fiscal year 1973 this bureau funded forty-one PA training programs. The bureau estimates that 1,430 students are enrolled in these programs at an expenditure of $6.3 million. A. Sadler, *Introducing a New Professional: The Health Practitioner*, in INTERMEDIATE LEVEL HEALTH PRACTITIONERS 10 (V. Lippard and E. Purcell eds. 1973) [hereinafter cited as Sadler].

[9]*Appendix H: Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician*, in A. SADLER, B. SADLER & A. BLISS, THE PHYSICIAN'S ASSISTANT — TODAY AND TOMORROW 220 (1972).

[10]Sadler, *supra* note 8, at 10-11.

[11]*See* NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER, REPORT OF THE NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER 31 (1967) [hereinafter cited as REPORT]. A nonphysician, which includes a person who has gone to medical school but has not duly graduated, cannot undertake any of the functions of a doctor. Note, *Paramedics and the Medical Manpower Shortage: The Case for Statutory Legitimization*, 60 GEO. L.J. 157, 159 (1971) [hereinafter cited as Note].

which these medical laws were formulated have changed drastically. The nature of medical aid has become much more complex, and there is a greater demand for health care personnel. Yet no fundamental changes have been made in the statutory standards of professional competence.[12] Ancillary categories of health workers have developed, but the tasks defined as comprising the practice of medicine[13] are still attributable by law only to two categories: the physician, who has at least twenty-one years of education and training, and the professional nurse, who may have as little as two years of formal education after high school.[14] The category of physician's assistant has been designed to help fill this gap in the health personnel scheme. Without specific legislative authorization, however, the practicing PA is vulnerable to the legal sanctions imposed upon people who practice medicine without a license.

Civil, criminal, and administrative sanctions are imposed for violation of medical laws. Under the long-standing doctrine of *respondeat superior*, the physician is responsible for the negligent acts of a PA under his employ. This liability exists whether or not the PA is authorized under state law to practice.[15] But if the PA is not authorized to practice, the physician could incur additional liability simply for using the PA, regardless of the PA's actual competence. If a physician restricts his personnel to tasks within an authorized sphere of activity, he is presumed to have delegated to competent, qualified personnel.[16] But if there is no state legislation pertaining to the scope of a PA's functions, there would be no presumption of competence no matter what functions he is assigned.

If the physician delegates to an unauthorized PA tasks which could be construed as being within the "practice of medicine", both the assistant and the physician may be prosecuted; the assistant, for the crime of the unlicensed practice of medicine, and the delegating physician, for aiding and abetting such crime.[17] Further, were the

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[12] Forgotson, Roemer and Newman, *Licensure of Physicians*, 1967 WASH. U.L.Q. 249.

[13] Most state medical practice statutes contain a broad definition of the term "practicing medicine", and require any person "who practices or attempts to practice, or who . . . diagnoses, treats, operates . . . or prescribes for any ailment, blemish . . . disease . . . " to be licensed as a physician. CAL. BUS. & PROF. CODE § 2141 (West Supp. 1974).

[14] REPORT, *supra* note 11, at 31.

[15] Leff, *Medical Devices and Paramedical Personnel: A Preliminary Context for Emerging Problems*, 1967 WASH. U.L.Q. 332, 336 [hereinafter cited as Leff].

[16] Anderson, *Licensure of Paramedical Personnel* 6, Address before 65th Annual Meeting of the Federation of State Medical Boards of the United States, February 7, 1969, in DEP'T OF COMMUNITY HEALTH SERVICES, DUKE UNIVERSITY, MODEL LEGISLATION PROJECT FOR PHYSICIAN'S ASSISTANTS 6 (1970) [hereinafter cited as DUKE PROJECT].

[17] *See* People v. Whittaker, 68 Cal. 2d 357, 66 Cal. Rptr. 710, 438 P.2d 358 (1968). Here, the conviction of the assistant was upheld as violation of CAL. BUS.

physician found guilty of the unlawful act of aiding and abetting the unlicensed practice of medicine, he would be then subject to administrative disciplinary action.[18] This would include the possibility of license revocation.[19]

The severity of these possible liabilities to both PA and physician suggests that authorizing legislation would be a crucial factor in legitimizing the role of the PA and in the development of a favorable legal environment for the growth of the PA as a profession.[20]

## B. PA LEGISLATION — WHAT SHOULD BE THE CONSIDERATIONS?

Two basic tenets underlie any considered approach to PA legislation. First, since the legislature is responsible for the health and welfare of its citizens, it must give primary consideration to the protection of the public in its receipt of health care.[21] Secondly, a certain amount of flexibility is necessary to insure the successful adoption of the PA by the medical profession. The key problem in drawing PA statutes is this tension between insuring a high quality level of treatment on the one hand and allowing for a functionally flexible source of available health care manpower on the other.

This tension is reflected in every specific aspect of formulating PA legislation and manifests itself in such problems as: (1) the allowable

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& PROF. CODE § 2141 (West Supp. 1974), and the physician was convicted of violation of CAL. PEN. CODE § 31 (West Supp. 1974) as aider and abettor of the crime.

[18] *E.g.*, CAL. BUS. & PROF. CODE § 2361 (West Supp. 1974), § 2372 (West Supp. 1974), § 2392 (West Supp. 1974).

[19] *See* Magit v. Board of Medical Examiners, 57 Cal. 2d 74, 17 Cal. Rptr. 488, 366 P.2d 816 (1961). Here, three foreign medical school graduates and experienced anesthesiologists, were held to have illegally practiced medicine due to failure to obtain licenses. The supervising physician was found guilty of aiding and abetting the acts of the three unauthorized specialists under CAL. BUS. & PROF. CODE § 2392 (West Supp. 1974), and his license was revoked (revocation of license by Board of Medical Examiners set aside as an abuse of discretion).

*Also*, Newhouse v. Board of Osteopathic Examiners, 159 Cal. App. 2d 728, 324 P.2d 687 (1958). In this case, the physician was found guilty of unprofessional conduct, CAL. BUS. & PROF. CODE § 2392 (West Supp. 1974), when he asked a licensed chiropractor to assist him in doing services that the chiropractor was not licensed to perform. The physician's license was suspended for thirty days, for aiding and abetting the acts of the chiropractor.

[20] For a fuller discussion of the liability in this area *see* Notes, *Tort Liability and the California Health Care Assistant*, 45 S. CAL. L. REV. 768 (1972); Leff, *supra* note 15, at 378-394; DUKE PROJECT, *supra* note 16, at 3-8; Note, *supra* note 11, at 158-164; and Ballenger, *The Physician's Assistant: Legal Considerations*, 45 J.A.H.A. 58, 58-59 (1971) [hereinafter cited as Ballenger].

*Also* E. Bernzweig, *The Malpractice Problem and the Use of Physician's Assistants*, in DEP'T OF HEALTH, EDUCATION AND WELFARE, APPENDIX: REPORT OF THE SECRETARY'S COMM'N ON MEDICAL MALPRACTICE 170 (1973); Comments, *The Physician's Assistant in California: A Better Legal Framework*, 12 SANTA CLARA LAWY. 107 (1972).

[21] Note, *supra* note 11, at 165.

scope of the PA's activity; (2) the amount of supervision required over him; (3) the extent, if any, that he be permitted to exercise independent judgment; and (4) the educational criteria required and the manner of his ultimate certification to practice.

The PA is viewed as part of a health team.[22] By definition he is physician-dependent. Ideally, he is directed and supervised by a physician who is able to determine the scope of his PA's activities on the basis of the PA's abilities and the doctor's own individual needs. It might be argued that the legislature must determine the scope of activities that it will allow the PA to perform, and that to insure public welfare, the legislature must specify exactly what tasks the physician's assistant should and should not be allowed to do. The danger of this approach is that the PA may be severely limited in his practice. Especially in the beginning, the PA may be given very little responsibility. The value of the PA concept lies in the fact that the PA can theoretically perform any function the physician feels that he is properly trained to do. By limiting the PA's tasks to those specifically enumerated, the law would severely limit the PA's effectiveness.

Physician supervision is inherent in the dependent status of the PA. But the degree of supervision is a debated issue. Should the physician be required to furnish direct over-the-shoulder supervision of the PA at all times? In training situations, the physician should closely supervise the PA, but it does not seem necessary to require the physician to personally supervise a trained PA who is performing routine work. If there were complications the PA would go to his physician (the PA should always be able to directly communicate with his physician), but he should be allowed to perform certain tasks independently of direct over-the-shoulder supervision.[23]

The PA should also be allowed to exercise some degree of independent judgment and analysis within the sphere of activity allowed to him. If he is well-trained enough to perform these tasks, he should be able to exercise some judgment as to them. The doctor would not have permitted him to perform if he had not been confident of the PA's competence.

The tension between the considerations of quality care and flexibility can be solved to some extent by putting the responsibility on the physician to allocate tasks and determine the degree of super-

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[22] For a collection of data and an analysis pertaining to the health team concept and the resulting allocation of tasks, *see* M. Peterson, *Interdependence: How Can the Team Play the Game?*, in INTERMEDIATE LEVEL HEALTH PRACTITIONERS 30 (V. Lippard and E. Purcell eds. 1973).

[23] For a discussion of the varying views on supervision *see* Dean, *State Legislation for Physician's Assistants*, 1 HEALTH SERV. REP. 3, 11-12 (1973) [hereinafter cited as Dean]. *Also see* Note, *supra* note 11, at 168-70.

vision and independent judgment. Allowing the physician to decide to what extent he will supervise his PA in certain tasks and to what extent he will permit his PA to exercise independent judgment puts the burden on the physician to insure the quality of care that the PA renders. The physician has a vested interest in his PA's performance because he would be liable for his PA's negligent acts. Maximum flexibility would be provided because the physician would determine, by his knowledge of the capabilities of each individual PA, what that PA might do. Some legislative safeguards should be provided, however, and various states' approaches to providing such safeguards will be examined later in the article.

Educational requirements and training qualifications should also remain flexible while maintaining some minimum standards of education and skill. The possibility should always be recognized that a person may have had previous experience that would obviate the need for him to complete the entire formal curriculum set up by a state. Weight should be placed upon previous training and experience when setting up educational requirements. In setting up a certification process — the final step in allowing a PA to practice — provision should be made for testing persons who have completed the formal educational requirements, as well as people who, by previous practical training, exhibit an equivalent level of proficiency.

## III. VARIOUS STATE APPROACHES TO PA LEGISLATION

As of June, 1972, eighty-four PA programs had been initiated throughout the United States.[24] By the end of 1972, legislation authorizing PAs to practice had been enacted in twenty-four states.[25] Legislatures had considered but rejected a variety of PA proposals in fifteen other states,[26] and the remaining eleven states had not entertained bills permitting physicians to delegate medical tasks to assistants.

### A. LICENSURE

Historically, official occupational licensure has almost exclusively controlled the allocation of tasks and responsibilities among members of the health manpower hierarchy.[27] Under this system the

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[24] H. Marcus, *The Effect of Fear of Litigation on Utilization of Physicians' Assistants*, in DEP'T OF HEALTH, EDUCATION AND WELFARE, APPENDIX: REPORT OF THE SECRETARY'S COMM'N ON MEDICAL MALPRACTICE 174 (1973).

[25] *See* note 7, *supra*.

[26] The states rejecting PA proposals were Hawaii, Illinois, Indiana, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, and Wisconsin. Dean, *supra* note 23, at 3.

[27] *See* DUKE PROJECT, *supra* note 16, at 3-5.

practice of medicine has been absolutely prohibited except by specially licensed individuals meeting certain minimum standards.

Recently, however, licensure has been severely criticized. Present occupational licensure laws tend to preserve the status quo, discouraging new allocations of responsibilities within the health manpower matrix and inhibiting experiments to test the safety and effectiveness of new manpower uses.[28] Licensure laws which in many jurisdictions specify course and curricular requirements, may unduly hamper medical education and training.[29] Although licensure laws do serve a function in measuring at least initial qualifications, it can be argued that the disadvantages of this approach outweigh the benefits in view of the other quality controls (such as program accreditation) which were not in existence when the licensure schemes originated.[30] It is questionable whether present licensure laws have solved even the problem for which they were designed; that is, protection of the public against the incompetent doctor.

The conclusion that licensure laws act as unnecessary barriers to educational advance, effective delegation of tasks, and innovation in manpower utilizations appear in position statements on licensure prepared in 1970 by the American Medical Association and the American Hospital Association.[31] The Department of Health, Education and Welfare concurs, and recommends a moratorium on requiring licensure in additional health occupations.[32] Their guidance has apparently been heeded: of all the states, only Colorado has enacted legislation providing for licensure of PAs.[33]

## B. OTHER APPROACHES

The remaining PA legislation basically falls into two categories.[34] One category of states has adopted a form of legislation whereby the state's medical practice act is simply amended to provide an exception for the PA to practice. The majority of states with PA legislation provide a more detailed framework by setting up a regulatory agency to promulgate rules and regulations for the workings of the PA profession.

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[28] Forgotson and Cook, *Innovations and Experiments in Uses of Health Manpower — The Effect of Licensure Laws*, 32 LAW & CONTEMP. PROB. 731, 732 (1967).
[29] *Id.* at 739.
[30] Roemer, *Licensing and Regulation of Medical and Medical-Related Practitioners in Health Service Teams*, DUKE PROJECT, *supra* note 16, at 13, address presented at Conference on the Role of Law in Medical Progress, Boulder, Colorado, March 20, 1970.
[31] SADLER, SADLER & BLISS, *supra* note 5, at 94.
[32] DEP'T OF HEALTH, EDUCATION AND WELFARE, REPORT ON LICENSURE AND RELATED HEALTH PERSONNEL CREDENTIALING (1971).
[33] COLO. REV. STAT. ANN. §§ 91-10-1 to -15 (Supp. 1969).
[34] *See generally* Dean, *supra* note 23. Dean formulates a chart listing each state's legislation and various characteristics thereof.

### *1. AMENDING THE MEDICAL PRACTICE ACT*

Seven states[35] have adopted a form of legislation whereby the state's medical practice act is simply amended to codify the right of a physician to delegate tasks to health personnel working under his supervision and control. Typical of this general delegatory amendment is the Connecticut statute. This states that the provision of the state Medical Practice Act defining the practice of medicine and providing that it be a criminal offense for one not licensed as a physician to perform these tasks "shall not apply to . . . any person rendering services as a physician's trained assistant, a registered nurse, or a licensed practical nurse if such service is rendered under the supervision, control, and responsibility of a licensed physician."[36] This language varies slightly from state to state, and the precise interpretations of what these various phrases mean — *e.g.*, continuous supervision, supervision of only certain tasks, over-the-shoulder supervision, etc. — will probably be defined in the courts on a case by case basis.

This type of legislation should be considered only a stop-gap method of providing for the PA to practice. The amendments make no attempt to define the tasks or the situations when the tasks may be delegated. Nor do they set up or designate any kind of regulatory agency to promulgate and administer guidelines. They do not set forth any definitive guidelines for PA qualifications — education, training, and experience. Without some educational guidelines, there is an unduly high risk that incompetent PAs may be hired. Some criteria are necessary so that the physician can measure the PA's capabilities against that level of competence that is desirable. This uncertainty may deter physicians from hiring PAs. While the functions of the PA should remain fluid, it seems that there should be some way for the PA's individual capabilities to be certified.

In the absence of a regulatory agency to put forth and administer more detailed rules, however, this approach may be best. Any detailed specification in the statute of how and when a PA should be supervised would take a step toward locking the PA into too rigid a role without regard for his individual capabilities. The amendments provide the PA with the opportunity to practice in these states, and they give maximum flexibility to the physician to decide what tasks

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[35]*See* ALAS. STAT. BUS. & PROF. § 8.64.170 (1973); ARK. STAT. 1947 ANN. § 72-604(p) (Supp. 1973); CONN. GEN'L. STAT. ANN. § 20-9 (Supp. 1973); DEL. CODE ANN. tit. 24, § 1731 (d)(6) (Supp. 1972); KAN. STAT. ANN. § 65-2896 (Supp. 1973); REV. CODES OF MONT. 1947 § 66-1012 (L) (1970). Colorado has a delegatory amendment statute as well as a detailed statute licensing a special category of the PA — the Child Health Associate — to practice within very special limits. *See* COLO. REV. STAT. ANN. § 91-1-6 (1964) and §§ 91-10-1 to -15 (Supp. 1969).

[36]CONN. GEN'L. STAT. ANN. § 20-9 (Supp. 1973).

the PA will perform. Also, they do provide for the supervision of the PA by the physician. However, in failing to provide for the other considerations supporting PA legislation — such as some sort of task analysis and educational criteria — they may not weigh properly the balance between the concern for patient welfare and the need for flexibility, and they serve at best as only temporary substitutes for more detailed legislation.

### *2. THE ESTABLISHMENT OF REGULATORY BOARDS*

The majority of states with PA legislation do not give the physician sole responsibility for determining educational qualifications and job assignments. These states usually authorize a specific organizational entity, such as the state board of medical examiners, to promulgate and administer rules and regulations pertaining to PA qualifications.

There are varying degrees of specificity and regulation in this type of legislation. The danger inherent in this delegation of power to the various administrative boards is that they will proceed to institute overly rigid rules and regulations for the PA, thereby approaching the effect of a traditional licensure statute. Analysis of the desirable and disadvantageous aspects of this form of regulation will be presented herein through an examination of the North Carolina and California PA legislation. Each statute delegates authority to the state board of medical examiners to approve prospective assistants and promulgate general guidelines for their activity. However, the power vested in the board differs significantly in the two states, leading ultimately to two very different kinds of regulation.

#### *a. The North Carolina Legislation*

North Carolina's PA training program, the nation's first, was distributing PAs throughout the state before permanent legislation was enacted.[37] Thus, the legislature had indications of the quality of performance, the practical aspects of the PA's duties, and the need for flexibility before it formulated the legislation.

The North Carolina statute is a simple amendment to the medical practice act, but differs from the general delegatory amendment discussed above in that it designates a regulatory body to promulgate the standards pertaining to PAs. The Medical Practice Act [38] describes the penalties for practicing medicine without a license and defines the practice of medicine. It goes on to say:

> Any person shall be regarded as practicing medicine or surgery within the meaning of this Article who shall diagnose or attempt to

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[37] DUKE PROJECT, *supra* note 16, at 14.
[38] GEN'L. STAT. OF N.C. § 90-18 (Supp. 1973).

> diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment . . . Provided, that the following cases shall not come within the definition above recited . . . (13) Any act, task or function performed by an assistant to a person licensed as a physician by the Board of Medical Examiners when a. Such assistant is approved by and annually registered with the Board as one qualified by training or experience to function as an assistant to a physician, except that no more than two assistants may be currently registered for any physician, and b. Such act, task or function is performed at the direction or under the supervision of such physician, in accordance with rules and regulations promulgated by the Board, and c. The services of the assistant are limited to assisting the physician in the particular field or fields for which the assistant has been trained, approved and registered . . . provided that this subdivision shall not limit or prevent any physician from delegating to a qualified person any acts, tasks or functions which are otherwise permitted by law or established by custom . . .[39]

The approach here was to add an additional exception to the Medical Practice Act for the physician-directed and supervised activities of a PA. The intent was to assign principal regulatory responsibilities to the physician, while preserving the role of the organized medical profession as having some impact with respect to these physician-dependent personnel.[40] Thus, the amendment provides that the PA must be approved by and registered with the Board, and that the PA's functions be performed at the direction of or under the supervision of the physician in accord with the Board's rules.

The necessary legislation exists to prevent the legal dangers of letting a PA practice without authorization. Flexibility is provided for the scope of tasks allowed to the PA because of the broad delegatory power granted to the physician. The physician exercises great autonomy in delegating tasks to his PA. The Board of Medical Examiners must first approve and register the assistant, however. This requirement acts to place a safeguard on the use of the PA. It insures that the PA is "one qualified by training or experience to function as an assistant to a physician,"[41] *before* the PA is authorized to practice. This registration must be annually renewed, thus insuring that the PA maintains his level of competency. An additional safeguard to patient welfare comes from the requirement that no more than two assistants can be supervised by any one physician. This acts to prevent the indiscriminate use of a PA who cannot be properly supervised because the physician is "spread too thin".

Supervision is required, but not in a highly specified manner. This allows the desired flexibility of leaving decisions largely up to the

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[39] GEN'L. STAT. OF N.C. § 90-18(13) (Supp. 1973).
[40] Ballenger, *supra* note 20, at 60.
[41] GEN'L. STAT. OF N.C. § 90-18(13)a (Supp. 1973).

physician who is best capable of determining what type of supervision his PA needs.

North Carolina's statute does not provide that the physician be approved by the Board, nor does it detail limitations on the PA beyond the requirements of prior approval and registration of the PA and general supervision. Basically, this legislative framework would seem to provide the essential considerations for public welfare. In requiring that the PA be approved in advance of practicing and annually registered, the statute insures that a PA will be appropriately qualified. In limiting the number of PAs to two for any physician, the statute insures that the physician will properly be able to supervise his PAs. And supervision is required in the broad language of "at the direction or under supervision of such physician".[42] This language leaves open the possibility of a PA functioning without over-the-shoulder supervision should his directing physician determine that he is qualified to do so. The physician's personal stake in the performance of his PA should act as a sufficient limitation upon indiscriminate assignment of tasks. Admittedly, there will be a definite plateau on the capabilities of the PA because he is not as extensively trained as a physician. If the PA is to perform more difficult tasks, the physician would have to train his PA, and his interest in patient welfare and in the performance of his PA should assure proper training. This flexible approach thus allows expansion of the PA's functions by further training. This is highly desirable. By providing for annual registration, there would be periodic reappraisal of the PA's capabilities, and his new functions could be considered and approved.

Lack of specificity as to educational requirements may be a disadvantage in this statute. There is no mention of approval of training programs or minimum criteria. Thus it is possible for persons trained in other states or persons with previous experience to qualify to work in North Carolina. However, provision for these contingencies could be expressly made in the statute while still providing for some minimum standards. Alternatively, the board's processes of approval may effectually deal with this problem.

*b. The California PA Legislation*

When first enacted in 1970, the California statute[43] was heralded as "the nation's most complete and comprehensive physician's assistant law".[44] The legislation attracted much nationwide attention, and several states patterned their legislation after California's.

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[42] GEN'L. STAT. OF N.C. § 90-18(13)b (Supp. 1973).
[43] CAL. BUS. & PROF. CODE §§ 2510-2522 (West Supp. 1974).
[44] Curran, *The California Physicians' Assistants' Law*, 283 N. ENG. J. OF MED. 1274 (1970) [hereinafter cited as Curran].

The statute begins with a legislative declaration that "In its concern with the growing shortage and geographic maldistribution of health care services in California, the Legislature intends to establish . . . a framework for development of a new category of health manpower — the physician's assistant . . ."[45] It goes on to urge utilization of PAs and says that the existing legal constraints should not be an unnecessary hindrance to the provision of health care. Another declared purpose is to allow "for more innovative development of programs for the education of physician's assistants".[46]

As with the North Carolina statute, the basic requirements are set forth in the statute. The PA must be approved prior to practicing, he must be supervised by the physician, and he must meet certain educational requirements. The scope of the PA's functions must also be approved by the board. The statute provides that a physician who desires to employ a PA must submit an application to the board, discussing the qualifications of the proposed PA, the background of the physician, and the way in which the PA is to be utilized in the physician's practice.[47]

The statute vests significant responsibility in the California Board of Medical Examiners. The board is authorized to issue prior approval for training programs;[48] to approve the assistants themselves; and to approve the physicians desiring to utilize assistants.[49] It then mandates the board to promulgate and adopt regulations to establish the criteria for these approvals and to otherwise carry out its purposes. The ultimate impact of the statute depends on the regulations promulgated by the board. "The success of the program in California now depends upon the imagination and good faith of the California Board of Medical Examiners."[50] The proposed rules and regulations did not issue from the board until more than a year after the statute was enacted. Thus, no PAs could qualify for work under the statute until then.

In general, the regulations themselves[51] have turned out to be unduly restrictive in their provision of a task list for the potential PA, in providing for educational requirements, in their requirements of supervision, and in various other aspects to be discussed.

The regulations provide a detailed list of tasks that are performable by an assistant to the primary care physician.[52] This list

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[45] CAL. BUS. & PROF. CODE § 2510 (West Supp. 1974).
[46] CAL. BUS. & PROF. CODE § 2510 (West Supp. 1974).
[47] CAL. BUS. & PROF. CODE § 2516 (West Supp. 1974).
[48] CAL. BUS. & PROF. CODE § § 2516-2517 (West Supp. 1974).
[49] CAL. BUS. & PROF. CODE § 2516 (West Supp. 1974).
[50] Curran, *supra* note 44.
[51] 16 CAL. ADMIN. CODE § § 1379-1379.75 (9-23-72, 5-5-73, 9-22-73, 1-22-72).
[52] 16 CAL. ADMIN. CODE § 1379.23 (1-22-72). The section reads "Specifically and by way of limitation, an assistant to the Primary Care Physician should be able to:" and proceeds to give a highly specific list of tasks.

covers tasks which include taking medical histories and performing physical examinations, specific tasks under the categories of following routine laboratory and screening techniques, routine therapeutic procedures, and other assistances to the physician. This section has desirable points such as allowing the PA to "[r]ecognize and evaluate situations which call for immediate attention of the Primary Care Physician and institute, when necessary, treatment procedures essential for the life of the patient."[53] The PA is allowed to exercise a degree of independent judgment, but only in an emergency situation. The disadvantages of such a detailed list are that, although specific reference is made to desirable responsibilities allowed to the PA, it names the things the PA can do — anything not specifically referred to is something the PA cannot do. This disadvantage may be nullified by the last statement in this section which states that the assistant may perform tasks in addition to those listed, under the supervision of the physician, if adequate training and proficiency can be demonstrated in a manner satisfactory to the board. But the decision is left to the board, rather than the physician, whether or not the PA will be allowed to perform these additional tasks. The way in which the board administers this proviso will determine its effectiveness in adding the desired flexibility to the task range.

Moreover, flexibility as to training concepts is curtailed by the educational requirements provided for in the regulations.[54] The statute provides that the board must approve a PA training program in advance and that the PA be a graduate of an approved program in order to perform those tasks listed in the regulations. This indicates that the board wants the PA to be trained in the educational setting of a school, and not on the job.[55] By placing this emphasis on the

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[53] 16 CAL. ADMIN. CODE § 1379.23(d) (1-22-72).

[54] 16 CAL. ADMIN. CODE §§ 1379.24-.25 (1-22-72, 9-23-72).

[55] In hearings held before the Assembly Select Committee on Health Manpower on the subject of Physician's Assistants in January and November 1972, this testimony was given by Dr. Paul Dugan, Chairman of the Advisory Board on Physicians' Assistant and Nurse Practitioner:

> It was the impression, I think, of the Advisory Committee and the Board that really the educational institutions, who is the mother here of the teaching, is really the place where these tasks should be taught. When the educational institution is requested by the supervising physician to teach, because of the need, then I think they are geared for training a certain task, and I am sure that will be acceptable to the Board, as Dr. Schoen said, if there is a need, the educational institution will do it. In most physician's offices, even in a large group practice there is neither the time nor the material to teach the task, and it is my impression that if the Drew School or Stanford, for example, will say we'll teach them to do whatever is requested in the field, and the field says there is a need, then the Board is going to say, fine.

*Hearings on Physician's Assistants Before a Select Committee on Health Manpower*, Cal. Leg. Assembly at 28 (November 1972) [hereinafter cited as *Hearings*].

formal education, the regulations seriously impair the ability of the PA to expand the scope of his functions by learning new tasks in on-the-job training. The capabilities of the PA are potentially ever-expanding because of the knowledge that he can gain from his physician, but these provisions made doubtful this expansion in California.

Besides restricting the potential of on-the-job training, the educational approval requirements also jeopardize the chances of an out-of-state PA to practice in California. In 1973, an amendment to the definition of the assistant to the primary care physician was adopted by the board which provides that a PA may be certified to practice by the board in California without taking the written examination: (a) if he has graduated from a PA program whose requirements are equal to or greater than those put forth for California and (b) if he has passed an exam for such certification that is, in the board's opinion, comparable to California's examination.[56] This provision thus includes in the California definition of a PA: (1) a PA who has graduated from an approved California program and who passes the board's certification examination and (2) a graduate of another state's program who meets the two requirements. This may alleviate the inflexibility heretofore discussed. The drawback is that again, the board may in its discretion decide if the out-of-state exam is comparable to California's. So the board can make the provision flexible or effectively inhibit the certification of other PAs despite the amendment.

The foregoing discussion brings to focus the great power granted to the Board of Medical Examiners. It has almost unlimited discretion. Moreover, the prior approval of programs grants it the power of accreditation.[57] The board is made up of physicians who should be the best persons to know the problems involved. But physicians have a vested interest in the medical profession which may influence their decisions. It is possible that they may be too closely connected with the new profession to make objective decisions about it. The delegation of such broad powers means that the determination of whether the program will be flexible or rigid vests in this one agency. This is a disadvantage of the California law. However, the alternative of making the legislation more specific is also disadvantageous because changing the content of a statute is a much more cumbersome task than making changes in a regulation.

The regulations define supervision as requiring the physician to consult with the PA and the patient before and after the rendering of routine laboratory, screening, and therapeutic procedures.[58] It places on the physician the responsibility of reviewing findings of the

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[56] 16 CAL. ADMIN. CODE § 1379.20 (9-22-73).
[57] SADLER, SADLER & BLISS, *supra* note 5, at 103-104.
[58] 16 CAL. ADMIN. CODE § 1379.22 (9-22-73).

history and physical examination and all follow up exams with the PA together with the patient. This definitely curtails the PA's effectiveness — it undermines the position of a competent PA and does very little to free the time of the physician. It severely limits the potential of the PA concept.

A further restrictive aspect of the regulations is in the area of informed consent. This regulation provides that "[n]o assistant . . . shall render general medical services to any patient . . . unless said patient has been informed that general medical services will be rendered by that Assistant under the supervision of the . . . Physician and has consented in writing prior to performance to permit such rendering of general medical services by said Assistant."[59] This, coupled with the provision that the PA must bear an identification badge "not less than two and one-half inches long . . . which shall in print not less than one-fourth inch in size state . . . the title 'Assistant to the Primary Care Physician'," [60] seems to relegate the profession of physician's assistant to a very menial level. After all, the PA has been trained in a program approved by the board, hired by a physician approved by the board, and himself been approved by the board. This should insure the capability of the PA to perform those tasks within his scope of activity. Additional consent and such pointed identification hardly seems necessary. No other health professional is required to have informed consent when giving an examination, taking a blood pressure, or giving an injection.[61]

In summary, it would appear that although the California PA legislation itself is a "basically sound" piece of legislation, adequately insuring patient welfare, the regulations promulgated pursuant to it have resulted in over-regulation of the new profession. There is danger that the profession will be highly curtailed in its attempt to develop to full potential. The long range effects are still to be realized, the full impact of these regulations cannot be analyzed — they are too new. However, to date, the PA profession in California is not growing in proportion to the need for the PA. The development of programs has been slow and the number of PAs is still very small. This is directly attributable to the restrictive regulations.[62] As

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[59] 16 CAL. ADMIN. CODE § 1379.2 (9-23-72).
[60] 16 CAL. ADMIN. CODE § 1379.28 (9-22-73).
[61] *Hearings*, *supra* note 55, at 52.
[62] This testimony from the PA Hearing by Dr. Kivell of the MEDEX program in Los Angeles reveals some of the results of the regulations:

> I think it is difficult to point to any single regulation and say that it is a totally unreasonable regulation. I think, rather, what we have seen, is an attempt to be prudent, cautious . . . But the cumulative effect has been that the regulations have become very restrictive, such that, as I sit here, I learn that Dr. Kay of the Southern California Permanente Group indicates that his institution is leery of accepting preceptees, that is, to provide physicians to train physician's

of March 1974, there were five approved programs for the training of physician's assistants in California.[63] Three of these programs have only been approved since 1973,[64] and since the California program requires two years of training, these three have not yet graduated any PAs. The first two established programs graduated their first classes in June of 1973. Of these thirty-five graduates, only ten are currently working as PAs in California.[65] Other applications for approval to work are either pending or have been denied. California has not yet given a certification exam, so those PAs who have been approved are working under temporary certification only. It is not yet known when the final certification exam will be given. Twenty physicians had been given interim approval to supervise PAs as of January 15, 1974. Perhaps California should reconsider the policies that are declared in the legislative intent of the PA laws and re-evaluate the BME regulations in accordance with these policies.

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> assistants in the preceptorship phase, that they would be reluctant to hire physician's assistants . . . We are finding the same sort of response from other physicians who will be responsible for hiring physician's assistants . . . I can understand the wariness of many other physicians that don't want to put up with that sort of hassle. In addition, I think that there have been very few programs, or perhaps no new programs that have started over the past two years to train assistants to the primary care physician. Those that have started, I think, feel, that though basically they may be in agreement with some of the educational requirements, they find that there isn't an opportunity for creative utilization and training of physician's assistants. The most worrisome thing to me . . . is the fact that our students, in anticipation of their graduation, are starting to see the possibility that employment will not be available to them in this state, that the terms of employment will not be satisfactory, that their options will be cut down, and at the same time they are being spoken to by people from other states who are most anxious to grab off our graduates . . . AB 2109, which is also known as the Duffy Bill, has as one of its purposes, and I quote, 'the removal of existing legal restraints that hinder the more effective provision of health care services.' And I am afraid the reverse has happened. A new layer of restraints has been added, and I think it is indeed fair . . . that PAs have had no impact on health care in California to date, and unless the prevailing climate changes, they will have no significant impact in the forseeable future.

*Hearings, supra* note 55, at 50-52.

[63]The five schools are Charles R. Drew Postgraduate Medical School, UCLA; Foothill College/Stanford University Hospital; Cerritos College, USC; Los Angeles City College, USC; and East Los Angeles Community College, USC. Information from printed matter distributed by the office of the California Board of Medical Examiners, Sacramento, April 1974.

[64]These three are the programs at Cerritos College, Los Angeles City College, and East Los Angeles Community College. Information from printed matter distributed by the office of the California Board of Medical Examiners, Sacramento, April 1974.

[65]This information and that which follows was obtained from the office of the California Board of Medical Examiners, Sacramento, April 1974.

## IV. RECOMMENDATIONS

The tension between the competing needs for quality health care and a flexible source of additional manpower must be resolved so that the first consideration is not sacrificed for the second, nor should the PA legislation over-regulate to a point that is unnecessary for patient welfare.

The best general approach is the exception to the medical practice act of the state. This amendment provides greater flexibility than setting up the traditional licensing scheme for the PA. By amending the medical practice act, the legislature simply provides that the PA will be allowed to practice in the state. The legislation should then designate an organizational entity such as the Board of Medical Examiners to promulgate the rules and regulations pertaining to PAs. This approach is preferable to detailed statutes because administrative rules are easier to change than is legislation. The statute should contain the general requirements that a PA must be registered and approved to practice, must be working under a licensed physician, and must have met the educational requirements put forth by the board. Specifications of these general requirements should be left to the board.

The physician should be allowed great independence and flexibility in assigning tasks to the PA; however, to insure public safety his autonomy should be circumscribed by the requirement that the regulatory board approve the PA. The board should approve the PAs according to established criteria of competency for performing specific tasks. Ideally, this approval should be on an individual basis. This would be more difficult to administer than a method permitting the PA to perform only a few tasks, but in the long run, much more effective and fulfilling.

The physician could be allowed to determine the capabilities of his individual PA, and then apply to the board for approval of his PA's scope of activity. The board could set up a method of certifying the PA's capabilities and then issue its approval or disapproval. The board would set up its criteria as to what qualifications would be necessary to perform each individual *task*, but it would not set out a *range* of tasks within which the PA would be rigidly restricted. Thus, as the PA grew more skilled, his mandate for performance could be expanded commensurate with his proficiency. This would allow maximum flexibility for the PA's role, while guarding the public welfare by requiring that the board certify the PA's capability each step of the way. Thus the approval would be on an individual basis wherein the board is approving the individual PA's proposed task list.

Supervision should be required by the statute but this should again be on a flexible basis. The specifications should be left to the regulatory board. The board could define graduated classifications of tasks — specifying what degree of supervision would be necessary

within each classification. Or, more desirably, the physician could specify the degree of supervision he felt the PA required with each of the tasks allocated to the PA and include this in the job description that he submits to the regulating board for approval. The supervising physician is probably the person best qualified to judge the PA's capabilities and decide when and for what tasks he needs supervision.

The legislation should provide minimum education requirements and leave to the board the responsibility of insuring that they are fulfilled. However, these requirements should be qualified by the proviso that PAs trained in other states can qualify to practice by taking an exam to test certain fundamental academic knowledge *and* by demonstrating their practical capabilities in an observed clinical situation. In certifying the graduate PAs from its own state, the board should similarly provide for certification in a way that will test both academic and practical knowledge. Further, the board should not be charged with approving training programs in addition to approving the PA. By setting forth minimum educational criteria that the PA must meet and by providing a comprehensive certification process, the board would be able to insure that well-qualified PAs are produced. Requiring the board to approve training programs in advance of their implementation inhibits the establishment of such programs and is an unnecessary regulation.

The regulation of the scope of the PA's tasks, the degree of supervision, the educational requirements, and the method of certifying the PA are the basic legislative concerns. To go beyond regulating these aspects of the PA's activities the state runs the risk of encumbering the PA profession with inhibitory requirements — unnecessary for public welfare and jeopardizing the growth of a valuable health manpower source.

## V. CONCLUSION

The PA has become one of the most valuable sources for alleviating the health manpower shortage in this country. To insure his success in this role, statutory authorization is needed to allow him to practice. State legislation authorizing the PA's use must be different from traditional medical practice acts. The indefinite status of the PA calls for flexibility of regulation to insure that the profession can develop to its full potential. However, the public's interest in high quality care must never be sacrificed. This tension calls for states to be creative and to look beyond tradition in formulating their PA legislation. The incentive to do so lies in the promise of better health care for our citizens.

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