To Practice or Not to Practice: Developing State Law and Policy on Physician Assistants

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Presented in this paper is an analysis of the regulations for physician assistants promulgated by state administrative agencies, usually the board of medical examiners, pursuant to statutory authority. These regulations represent a further step in the evolution of state policy concerning this new health manpower occupation. Although there is considerable variability in the regulatory approaches that have been adopted to date, the paper points out certain provisions that may especially inhibit or facilitate the wide utilization of the physician assistant. Notwithstanding certain excellent provisions found in some of the states' rules and regulations, there does not appear to be, at this time, a model regulatory system.

Primary attention of the paper is focused on those regulatory issues that have most immediate and direct bearing on the education and employment of physician assistants. These include approval of training programs, job description requirements, approval of the supervising physician, supervision of the physician assistant, mechanisms for assuring continued competence, and disciplinary procedures. In addition, certain recommendations are made that would encourage greater uniformity in the state regulations.

The recent advent of the physician assistant phenomenon—in which a specially trained non-physician practices medicine under the supervision of a physician—has generated extraordinary interest and conjecture. While physician assistants are still relatively few in number, the concept represents a bold departure from traditional medical education and practice, as well as a potential solution to the problem of physician maldistribution. One area of particular interest and concern has to do with the legal and public policy issues centering on the practice of medicine (albeit a limited and circumscribed degree of medicine) by a non-physician. Recognizing that health manpower roles and responsibilities, generally, are in large measure determined by the numerous state laws that define the scopes of practice in the health professions, it is not surprising that the legal issues in this area have gained such

prominence in the ensuing discussion and deliberations on the physician assistant.

This paper provides a current analysis of the law and policy that have developed in the states in response to the physician assistant (hereafter, PA) concept. In contrast to earlier studies (Curran, 1970a; Willig, 1971; Ballenger, 1971; Georgetown Law Journal, 1971; Sadler and Sadler, 1971; Pratt, 1972; Dean, 1973; Howard and Ball, 1973; Barkin, 1974) that were based almost exclusively upon the *statutory* law relating to PAs and the need for statutory recognition of the PA, this paper will focus on a later point in the evolution of state policy, i.e., the adoption of administrative rules and regulations. Thus the present study contributes to the previous work in this area not only a more current analysis of public policy, but also a more realistic appraisal, based upon the state regulations, of what the PA may or may not do.

It should be pointed out that we are still not able to speak very concretely about the states' actual *implementation* their PA laws and regulations. We are dealing, of course, with a very current and fluid policy issue, and one with potential for substantial administrative discretion. Generally, the greater prominence of discretionary action over formal rules in administrative behavior is due to the fact that in a large number of policy issues either "no one knows how to formulate rules," or "discretion is preferred to any rules that might be formulated" (Davis, 1969:15). Certainly this is the case with regard to state policy on PAs. Notwithstanding the detail provided in some of the statues and regulations, a greal deal of discretion is afforded to each of the parties involved in the state's regulation of the PA. Subsequent studies of PA law will need to address systematically the actual implementation of such policy, and attempt to evaluate the impact of specific regulatory provisions.

As mentioned above, writers on this subject have pointed out the need for statutory recognition of the PA so that both he and his supervising physician (hereafter, SP) would be accorded legal protection from charges of practicing medicine without a license or aiding and abetting the illegal practice of medicine. Thirty-seven states have enacted legislation permitting PAs to practice under the supervision and direction of a physician. Although specific details of the PA statutes vary considerably, they take two basic forms: One form of PA law, the *general-delegatory model*, is an amend-

ment to the medical practice act that gives the physician authority to utilize a PA under his direction and supervision. No other formal requirements are provided, and the SP is thus accorded the widest latitude in selection and utilization of the PA. Seven states have enacted this type of amendment to the medical practice act, which is exemplified by the language of the Connecticut statute:

> The provisions of this chapter (Medical Practice Act) shall not apply to . . . any person rendering service as a physician's trained assistant, a registered nurse, or licensed practical nurse if such service is rendered under the supervision, control, and responsibility of a licensed physician.

Some of the pros and cons of this type of statutory approach have been discussed previously (see Dean, 1973) and, therefore, will not be repeated in this paper. The second form of PA law, the *regulatory-authority model*, authorizes a state agency, generally the state board of medical examiners, to develop and implement rules and regulations governing the education and practice of PAs. To date, 30 states have enacted this form of legislation. Note that Colorado has both a general-delegatory statute as well as the unique Child Health Associate Law which, for purposes of this paper, will not be considered a PA statute (Curran, 1970b; Silver, 1971; Cohen and Miike, 1973:4-5).

The analysis contained in this paper is based upon the most current PA statutes and regulations obtained from state agencies. Of the 30 states with regulatory-authority statutes, 10 states (Alaska, Hawaii, Iowa, Maryland, Massachusetts, Michigan, Nevada, South Carolina, South Dakota, and Wisconsin) had not yet issued PA rules and regulations at the time this information was collected, in early 1974. In most instances, the statutes in these statutes in these states had been enacted only within the last year or so, thereby not permitting adequate time for the formulation of rules and regulations.

In compiling the current laws and regulations on PAs, the authors also addressed two questions to each of the state agencies responsible for approving PAs. One dealt with the number of PAs that already had been approved in each state. This information is included in the following table. Approximately 650 PAs have been approved for practice, including PAs employed in states with general-delegatory statutes. Although the total number of ap-

proved PAs appears small when compared to the membership of other health occupations, it should be stressed that most PAs have been approved only within the last three years, and that educational programs are just now reaching the point where sizable numbers of PAs are being trained. Therefore, one may expect that the number of PAs will increase dramatically within the next several years, especially with increased federal support of PA training. The number of approved PA applicants, as listed in the table, also gives some indication of the administrative burden placed on various state regulatory agencies, an issue that is discussed again later in the paper. Our survey, incidentally, also confirmed one of the features of the general-delegatory statute discussed elsewhere (Dean, 1973:6); i.e., without state involvement in the PA approval process, data on the number and location of PAs practicing in the state are not usually available. We were also interested in obtaining information from the states on any litigation involving PAs since enactment of the PA statute, but no such litigation was reported.

Regulating the Education and Training Process

While most of the state regulations require that the PA complete an approved training program, there is substantial variability in the specific approaches taken in regulating the education and training process. In many respects, this particular area of regulation is characterized by an even greater range or continuum of regulatory authority than the regulation of the individual PA. At the one extreme, some states are completely silent about the educational training process (although in addressing the PA's qualifications for state certification there may be some reference to his completing a PA training program, which is generally a minimum of two academic years). At the other extreme, states have assumed control over virtually *every* aspect of the PA educational program. Between these two poles, one finds a sweeping range of requirements that give the states control over the establishment, recognition, and functioning of PA training programs.

Medical School or University Sponsorship

A number of states stipulate that the education and training of PAs must be linked to the medical education system in order to be ap-

Physician Assistants Approved by States
(As of March 1, 1974)

State	*Number of Approved PAs*	*State*	*Number of Approved PAs*
Alabama	23	Nebraska	2
Alaska	26	Nevada	0
Arizona	5	New Hampshire	24
Arkansas	5[a]	New Mexico	6
California	10	New York	128
Colorado	NA[b,c]	North Carolina	75
Connecticut	NA	Oklahoma	19
Delaware	NA	Oregon	58
Florida	30	South Carolina	NA
Georgia	48	South Dakota	NA
Hawaii	NA	Tennessee	NA
Idaho	13	Utah	19
Iowa	12[d]	Vermont	9
Kansas	NA	Virginia	50[e]
Maine	NA	Washington	57
Maryland	NA	West Virginia	28
Massachusetts	NA	Wisconsin	NA
Michigan	NA	Wyoming	6
Montana	2[a]	Total	655

[a] In some states with general-delegatory statutes, such as Arkansas and Montana, accurate information on the number of PAs practicing in the state is not available and the number reported pertains to those PAs in practice who are known to the agency reporting.

[b] Not available.

[c] The number of PAs practicing under the Colorado general-delegatory statute is not available. However, it was reported that there are 23 approved "child health associates."

[d] Iowa is permitting PAs to practice pending promulgation of regulations.

[e] Includes both nurse practitioners and physician assistants. No breakdown available regarding the number of physician assistants.

proved by the state. Alabama, for example, requires that the PA "training program must be sponsored by a four year medical college or university with appropriate arrangements for the clinical training of its students, such as a hospital maintaining a teaching

program." To be sure, this approach provides the opportunity to conduct PA training in close proximity to the training of physicians which may serve to enhance the level of sophistication and breadth of a PA training program.

But there are also potential drawbacks associated with medical school or university-hospital sponsorship that need to be considered. One is that it might preclude recognition of alternative training modalities capable of producing a significant supply of competent PAs in a given state. The military corpsmen, recognized in one state, for example, as eligible to take the RN licensure examination, certainly represent a potential source of PA manpower. In addition, the community colleges could conceivably train large numbers of competent PAs but probably would not be approved in states requiring medical school or university-hospital sponsorship of PA training. Furthermore, by placing PA training within the medical education structure, the state regulations may have added to the PA credentialing process a new and potent actor, the medical school. Conceivably, some medical schools may consider the rapid development and growth of PAs as not being in the best interests of the medical profession. Thus, placing such training programs within the medical education system may be viewed as one means of checking the development of this occupational category.

Required State or National Accreditation of the PA Program

A number of states require that the PA training program be accredited by a national organization such as the Council on Medical Education of the American Medical Association in order to be approved by the state. Other agencies whose approval of a training program will satisfy a state's accreditation requirements include: the American Association of Medical Colleges, the American Osteopathic Association, the National Commission on Accrediting, the Department of Health, Education, and Welfare, the Department of Defense, and, at the state level, the department of education or board of medical examiners.

In delegating control of the *accreditation* process to national medical organizations, some states appear to have placed PA training and credentialing very heavily within the medical education

system. In light of the recommendations by the Study of Accreditation of Selected Health Educational Programs (National Commission on Accrediting, 1972), urging adoption of a more broadly representative accrediting body for the allied health professions than the AMA's Council on Medical Education, some will surely question whether this same organization should be given such vast authority in the accrediting of PA programs as well. One must remember, of course, that in almost every instance, the administrative regulations for PAs were formulated by state boards of medical examiners. Thus the developing policy with respect to PAs is very much influenced by the same considerations of self-regulation and autonomy that characterize the role of professions in the licensure process (Cohen, 1973a).

Qualifications and Responsibility of Teaching Staff

Only a few of the states with regulatory authority in the area of PA training have specific requirements for preceptors and other teaching staff in the training programs. In these instances, the preceptor must be a licensed physician and generally must be present at the site of the training program. In some states, there appears to be sufficient flexibility in the requisite supervision of PA trainees in much the same way that the SP's supervision of the *practicing* PA is governed by the rule of "reasonable proximity to the physician."

In Vermont, the instructing physician must also certify to the department of health that a training plan was undertaken that includes specific skill objectives, performance standards expected of both parties involved, and a method of evaluation. This statement must be jointly signed by the PA and the teaching physician. Wyoming requires physicians involved in the training of PAs to register with the state and to provide the names of the PA trainees. This practice would appear to depart from that of other state-approved manpower categories.

Periodic Reports to the State

A number of states require the PA training programs to provide periodic evaluative reports on various aspects of the program. The

Alabama regulations stipulate, for example, that in order to retain recognition, the training program must make available to the board of medical examiners annual summaries of case loads and educational activities including volume of outpatient visits, number of inpatients, and the operating budget, as well as a satisfactory record of the entrance qualifications and evaluations of all work done by each student. In addition, it must notify the board in writing of any major changes in the curriculum or a change in the directorship of the program.

Periodic Renewal of Program Approval

Approval of the PA training program in several states must be renewed periodically. In some instances, this is merely implied in the requirement of the program to report periodically to the state. Thus, if a program were to report major shifts in curriculum, directorship, or supervision, it is reasonable to expect that the state might rescind its approval of the program. It should be noted that the present disparity among the states with regard to approval of PA training programs may be due for some change. The AMA's recently published essentials (American Medical Association, 1974), dealing with curriculum, preceptorship, advisory committees, clinical instruction, and facilities of PA training programs, may bring about much greater uniformity in the states' regulation of PA training.

Equivalency and Proficiency Alternatives

The education and training of the PA is certainly a critical requirement in most of the regulations and, as pointed out above, is spelled out in considerable detail in several instances. But, as in other categories of health manpower, there are several alternative pathways that the PA applicant may present in lieu of the generally prescribed educational program. Such equivalency measures are extremely important in the area of PA credentialing for at least two reasons: First, this may facilitate the deployment into needed civilian positions of military corpsmen who otherwise might not

qualify because of the educational requirements for state approval. Second, the PA concept is so new and dynamic that alternative options must be provided that recognize quality training of a different structure than that formalized in any given state. As noted by Cohen and Miike (1973:33-37), there is a growing acceptance in other health fields, as well, of educational equivalency designed to promote the more efficient utilization of manpower.

Several different approaches related to equivalency are found in the PA regulations. Vermont requires that candidates for PA registration shall have completed one of the following (a) a recognized PA program, (b) two years of nursing school, (c) one year of medical school or school of osteopathy and one year of experience and training under a physician, or (d) two years of experience and training under a physician. In the latter two alternatives, the PA must have been trained to perform certain services listed in the regulations as the requisite PA skills. Vermont appears to be the only state that goes so far with the equivalency approach as to approve the PA without *any* didactic training—which would be the case if the candidate presented two years of experience under a physician as the basis of his PA training. In contrast, California permits full academic credit through equivalency measures, but provides that no student shall be graduated unless a minimum period of one year is spent in residence in full-time clinical training with direct patient contact.

The Georgia regulations require graduation from an approved PA program "or satisfactory completion of a formal course of study in the health field combined with actual work experience related to the program of study such that the total of these two segments would cover at least four years, provided that the combined study and experience of such applicant is consistent with the job description contained in the application." Equivalency in this case is interpreted almost in a "compensatory" fashion, with the applicant needing *four* years of substitute training instead of the two-year, formal PA program. In New York, the state health commissioner has the discretion of accepting—in lieu of all or part of an approved PA training program—evidence of an extensive health-oriented education and of appropriate experience and training. He may also require the applicant to pass a proficiency examination, which will be discussed below, and to make up deficiencies in his

education or experience prior to registration. And, in Wyoming, the applicant may take an equivalency *examination* in lieu of completing a PA training program (although it is not clear whether the examination may be substituted for all or just part of the requisite didactic training).

The issue of educational equivalency also comes up in relationship to interstate reciprocity. Needless to say, an approved PA who moves across state lines may be faced with a different set of state requirements for PA approval. In the few state regulations that explicitly address the question of reciprocity, e.g., California and New York, PA applicants approved in other states must demonstrate that they have met equivalent educational requirements. But even in the majority of states that are silent on the issue of reciprocity, it is probably reasonable to infer such policy if the applicant can successfully demonstrate that his training was equivalent to the requirements of the new state.

With regard to proficiency testing, or the measurement of an individual's competency to perform at a certain job level (U. S. Department of Health, Education, and Welfare, 1971:53), five states (Alabama, New York, Oklahoma, Virginia, and Wyoming) authorize the use of proficiency testing, although the precise standards and the types of examinations are not spelled out. Maine and New Mexico permit PAs to practice if they have passed the national examination for assistants to the primary care physician developed by the National Board of Medical Examiners (NBME). In Nebraska, PAs may be approved who have been certified "under a national certification program of the American Medical Association's Council on Medical Education as 'program equivalent trained persons'; provided some measure of competency testing is utilized by the Council of Medical Education, such as the test developed by the National Board of Medical Examiners." In this connection, it is of interest to note that the states have been urged to adopt these certification measures, particularly the NBME examination, to satisfy the state requirements for professional competence of the PA (Casterline, 1974:119; Todd, 1972:566).

Although the number of PAs who have been approved by means of proficiency or equivalency mechanisms is not known at this time, it is clear that the laws and regulations, for the most part, provide relatively broad latitude for employing such mechanisms.

The major obstacles to utilization of these mechanisms will probably not be posed by the presence of legal restrictions, as is the case in other health manpower categories, but by the operational complexity of developing reliable tests for measuring competency and in defining what constitutes an appropriate substitution for PA training.

According to Casterline (1974:120), evaluation of the PA's on-the-job training and experience will ultimately require validation by the SP, who is subject to regulation by his own state board of medical examiners. This assumes, of course, that the medical boards are viable and effective monitors of the professional competence of practicing physicians. However, as we point out below with regard to board discipline and sanctions, this assumption rests on very shaky ground.

Job Description

Among the several provisions incorporated in the PA statutes and regulations to afford suitable protection for the public is the requirement that a job description be submitted together with the application to the state for PA approval. Seventeen states (Alabama, California, Florida, Georgia, Idaho, Iowa, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, South Dakota, Vermont, Virginia, Washington, West Virginia, and Wyoming) require such job descriptions which typically must list in detail all tasks that the SP might delegate to the PA. The PA must also indicate that he has sufficient training and ability to perform the functions listed in the job description. Generally, the state regulatory body is also authorized to require that the PA demonstrate his competence, if this is deemed necessary to make a thorough evaluation of the PA's qualifications.

In some states (Alabama, California, New Hampshire, Vermont, Virginia, and Wyoming), the regulations contain a *detailed* list of tasks that may be performed by the PA. Notwithstanding the inclusion of such lists in the regulations, *elastic* clauses may be found that permit the PA to perform additional duties, provided his competency to assume greater responsiblity is appropriately demonstrated to the regulatory body. This suggests, therefore, that

the PA regulatory agencies have substantial discretion in approving the roles and duties that can be assumed by a particular PA. In states where job descriptions are required, the PA has the option of demonstrating advanced or specialized skills and, thereby, to receive approval to practice in accordance with his unique training and skills. Where the regulations do not require a job description or provide a detailed task list, there is an implied authority for the PA to perform, under the direction and supervision of a physician, those tasks that he is competent to perform.

Job descriptions may provide a useful mechanism for regulatory agencies to determine how a PA will be utilized by a physician. This is especially important in light of the fact that PA training programs remain diversified in terms of content and that no single standard for PA competency has been agreed upon. Nevertheless, there are several potential disadvantages to the job description requirement. Administratively, it places upon the regulatory agency the burden of reviewing each application on an individual basis. Each application must be reviewed to compare the training and experience of the PA to the proposed list of functions that he will perform. In cases where questions are raised about the capability of the PA to perform certain tasks, an effort must be made to determine the PA's qualifications by means of interviews, examinations, or some other method. In some states, the regulatory agency is required to interview both the PA and the SP. Needless to say, this is an extremely time-consuming process and may seriously strain the resources of the regulatory agency if a large number of applications are received. This is particularly the case in those states where the members of the regulatory agency serve on a volunteer basis and have but modest staff resources.

Another potential difficulty relates to liability of the PA and SP in the event that the PA does not adhere to the approved job description. It would appear that in most states this could result in withdrawing the SP's right to employ a PA, as well as the PA's right to practice. Additionally, an injured patient in a malpractice action might receive the benefit of a legal inference of negligence if it can be shown that the injury occurred while the PA was functioning beyond the limitations of his job description. This possibility clearly underlines the need for both the PA and the SP to stay within the bounds of the job description. As the PA acquires the

skill to perform additional procedures, the job description should be amended before new duties are assigned.

State Approval of the SP

The fact that PAs or, in many instances, the PA training programs, must be approved by the state is not at all unique, and resembles the same fundamental approaches found in the credentialing requirements of other categories of health manpower. However, what is unique with respect to the state's regulation of PAs is the requirement in a number of states that not only the PA be approved but the SP as well. This opens up a new avenue of controls not generally found in other areas of state manpower regulation. Casterline (1974:120-121) justifies the need for this approach:

> A substantial number of statutory exemptions in many licensing jurisdictions allow physician's assistants *to practice medicine* under the direct supervision of a physician. In such cases, the physician must have more than a casual relationship with his PA. Often an employment contract stipulates the responsibility of the physician and his assistant and the duties the PA will be authorized to perform. Such a contract and "job description" when filed with a board of medical examiners then becomes documentation relating to the continued licensure of the physician as well as the registration of the PA. Therefore, . . it is important for state medical boards to assume the responsiblity of approving, in essence, the physician-mentor to serve in that role.

Another commentator (Howard, 1972:102) notes that the early thinking on PA legislation was largely based on the notion that "because the physician's assistant works in close relationship with the physician, the physician is in the best position to know the extent of his competence and should be relied on as the primary regulator of his activity."

In the case of California the SP must provide the state board of medical examiners with detailed information on his own qualifications to supervise the PA. Specifically, the California regulations require the SP to submit the following information:

> The professional background and specialty of the proposed Supervising Physician, information pertaining to the medical

> education, internship and residency of said physician, enrollment in continuing educational programs by said physician, membership or eligibility therefor in American Boards in any of the recognized areas of medical specialty by said physician, hospitals where staff privileges have been granted, the number of said physician's certificate to practice medicine and surgery in the State of California, and such other information the Board deems necessary. Participation by the proposed Supervising Physician as a preceptor in an approved educational program for an Assistant to the Primary Care or Specialist Physician should be indicated and whether the proposed Physician's Assistant was supervised by said physician pursuant to such preceptorship program. The application should indicate the number of other Physician's Assistants supervised by the proposed Supervising Physician and whether any other applications to supervise a Physician's Assistant have been filed with the Board which are then pending. A description by the physician of his practice, including the nature thereof and the location and the way in which the Assistant is to be utilized.

In addition, the California regulations include as one of the grounds for either denying approval initially to supervise a PA or subsequently revoking, suspending, or placing on probation such approval "the failure of the Supervising Physician to participate in and meet the minimum requirements of a continuing education program satisfactory to the Board." It should be noted that this requirement is inconsistent with the state's present licensure requirements of other physicians who do not supervise PAs (where the state does not now require continuing education as a condition to practice medicine). Given this disparity between the regulation of SPs on the one hand and the general physician population on the other, one would anticipate a "chilling" effect from such a provision that discourages widespread utilization of PAs by California physicians. Similar comments will be made below on some of the other provisions of California's PA policy.

Other examples of controls on the SP are the requirement in Nebraska of a signed statement by the SP that he will not delegate or authorize any PA to engage in any of the health professions, other than medicine or surgery, unless such PA has the proper license therefor. And in Alabama the SP must have been in practice for at least five years (three years for a board-certified specialist) to

be eligible to supervise a PA.

While in most cases the regulations do not specifically require the approval of the SP, such authority is at least implied in the large number of states that require the SP to provide the state with a job description for the proposed PA. Certainly, it can be argued that if a proposed job description revealed a fundamental lack of understanding on the part of the SP as to the tasks that a PA was capable or incapable of performing, the situation would be scrutinized, and possibly result in rejection of the application. It should also be noted, with respect to approval of the SP, that in some states the applicant for PA approval is the SP acting in behalf of the PA (and in a number of instances it is the SP who must pay the application fees and not the PA).

Supervision

Although the statutory language with regard to supervision may vary, each of the state laws and regulations indicates that the PA is to function in a *dependent* or agency relationship to his SP. A relationship of this type obviously suggests that the SP must assume responsibility for the proper supervision of his PA, and, to this end, the statutes and regulations governing this supervisory requirement take several forms. To ensure that no SP employs more PAs than he is theoretically capable of supervising, most of the statutes and regulations limit the number of PAs that can be employed. Seven states (Alabama, Arizona, Colorado, Idaho, Nevada, Oregon, and Washington) allow only one PA per physician, while 14 states (California, Florida, Georgia, Iowa, Maine, Massachusetts, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Oklahoma, Virginia, and Wyoming) allow two PAs per physician. The remaining 16 states with PA laws have not addressed this issue, either statutorily or in the administrative regulations. Clearly, this type of limitation does not *guarantee* that the physician will provide adequate supervision of the PA, but it does prevent one potential abuse of the PA concept by physicians who might be willing to incur risks of civil liability by employing large numbers of PAs in order to enhance the scope and potential profitability of their practices.

For the most part, the PA statutes do not provide the specific requirements for PA supervision; most of the laws simply declare that the PA must practice under the "supervision and control" of the physician. Responsibility, however, for defining the level and type of requisite supervision is delegated to the state administrative agency that must approve PAs. In response to this authority, these agencies have developed a variety of definitions and requirements for supervision. Most PA regulations do not require direct, over-the-shoulder supervision of the PA by the physician. The North Carolina regulations examplify this approach:

> The assistant must generally function in reasonable proximity to the physician. If he is to perform duties away from the responsible physician, such physician must clearly specify to the Board those circumstances which would justify this action and the written policies established to protect the patient.

A similar provision appears in the regulations of five other states (Alabama, Florida, Virginia, West Virginia, and Wyoming).

Although this type of language presents some interpretative problems such as what is meant by the terms "reasonable proximity" or "perform duties away from the responsible physician," it does allow for flexibility so that the regulatory body can meet unique problems that may arise. For example, if a physician in an isolated rural area were to seek permission to utilize a PA outside of the office setting and without personal, direct supervision, the state body would have an opportunity to review all aspects of the matter, including medical care needs in the area and PA qualifications, and then make a decision on the merits of the individual case. Obviously, this type of regulatory approach vests a great deal of discretionary power in the hands of the regulatory agency—which, incidentally, poses a number of administrative law issues. Operationally, it means that the agency may have to spend a considerable amount of time making decisions on a case-by-case basis.

In three states (Maine, New York, and Oklahoma), the SP is not required to be physically present when the PA is providing services, but neither is there any further clarification or specification concerning standards of supervision. Unless there is some provision in the regulations to furnish guidance on this point, the burden seems to fall on the SP to determine how he will supervise

his PA. This ambiguity is removed to some extent in Oklahoma by the requirement there that the SP submit a job description outlining how he intends to utilize the PA.

The question of over-the-shoulder supervision is approached in another way by Georgia, Nebraska, and Washington. These states stipulate that the SP need not be physically present when the PA is performing his delegated tasks so long as the PA is functioning in the office or normal place of practice of the SP. Georgia also allows the PA to make house calls, hospital rounds, serve as an ambulance attendant, or perform functions normally performed by the SP, if the PA is qualified. Here, again, the amount and type of supervision required when the PA performs these functions is not spelled out.

Nebraska further liberalizes its supervision requirement by stating that personal presence of the SP is not required if the PA functions in a licensed hospital where his SP is a member of the medical staff and where the hospital board has given its approval. The PA may also deliver care outside of the office or hospital setting (a) if the patients are specifically named and designated on a daily basis, and (b) if the geographical location of such PA functions is identical to the places of primary practice of the SP. The state of Washington permits certain types of well-qualified PAs to practice in remote areas away from the SP provided that approval is obtained from the state's board of medical examiners. The regulations, however, require that the SP review at least weekly all patient care provided by the PA if such care is rendered without direct consultation of the SP. The SP is also required to countersign all notes made by the PA.

In Arizona and Oregon, another approach to supervision is taken. The regulations in these states stipulate that a PA shall not exercise independent judgment in making a diagnosis or prescribing treatment except in life-threatening emergencies. The PA is required to report the results of his examination to the SP who then makes the diagnosis and prescribes the treatment. An even more restrictive approach governing the method of PA performance is found in the California and New Hampshire regulations:

> Supervision of an Assistant to the Primary Care Physician . . . refers to the responsibility of the Primary Care Physician to review findings of the history and physical examination . . . and all follow-

> up physical examinations with said Assistant together with the patient at the time of completion of such history and physical examination and to consult with said assistant and patient before and after the rendering of routine laboratory and screening techniques and therapeutic procedures . . . , excepting where the rendering of routine laboratory and screening techniques are part of the history and physical examination or follow-up examination performed.

These regulations do point out, however, that the presence of the SP is not required when the PA attends chronically ill patients at home, in nursing homes, or in extended-care facilities if such activity is for the sole purpose of collecting data for the SP.

The relatively strict approach to PA supervision evident in the Arizona, Oregon, California, and New Hampshire regulations poses a serious question as to whether PAs in these states will be able to fully utilize their training and experience. Advocates of the PA concept maintain that one of the primary objectives of this new category of health manpower is to relieve the physician of time-consuming, routine duties so that he may concentrate greater effort on more complex and demanding medical problems. Theoretically, the PA, with his special training and clinical experience, would be capable of examining patients, making some determination about the severity of their illnesses, referring to the physician those cases beyond his competence, and treating those problems that are within his competence. This *modus operandi*, if followed, implies that the PA must make some independent diagnostic and treatment decisions.

In barring the PA from making independent judgments relating to diagnosis and treatment, the Arizona and Oregon regulations have relegated the PA to a much more restricted role than is probably necessary, and have taken a markedly different approach from the majority of states with PA regulations. If the regulations are rigidly adhered to by physicians and PAs in these two states, the PA role may evolve into that of a technician responsible for conducting examinations, tests, and certain routine treatment procedures without being above to exercise any form of independent judgment. This requirement, by its very nature, would mean that the PA must function near the physician. Accordingly, opportunities for utilizing the PA's skills in remote settings may not be available. It should be pointed out that these restrictions ap-

parently have not curtailed PA registration in Oregon. As of March 1, 1974, the Oregon Board of Medical Examiners had approved 58 PAs, which represents one of the largest number of approvals among states with regulatory-authority statutes. Arizona had approved five PAs as of the same date, but the Arizona PA law was not enacted until 1972—a year after the Oregon law.

The supervision requirements promulgated in both California and New Hampshire also raise certain questions as to whether the PA might not be a potential liability to the physician. According to the regulations, the SP must consult with the PA after completion of a history and physical examination, and with *both* the patient and the PA before and after rendering treatment procedures. Such strict requirements for physician consultation and supervision involving all treatment procedures would dictate that the physician spend an inordinate amount of time consulting with patients and PAs, and may result in confining the PA's role to physical examinations only. This would certainly negate many of the advantages of PA employment altogether.

From a practical standpoint, the requirement that the PA practice in *reasonable* proximity to the physician unless otherwise authorized by the regulatory agency is probably the most prudent approach to take at the present time. This policy, along with a required position description, a limitation on the number of PAs per physician, and the statement that the SP in all cases is responsible for the acts of the PA, would appear to provide (a) the necessary flexibility to determine how PAs can be employed most effectively and efficiently, and (b) a reasonable degree of protection for the public.

Patient Consent

Three states (California, Virginia, and Washington) require consent of the patient before services may be rendered by a PA. The Washington regulations merely stipulate that informed consent will be required. California and Virginia, however, mandate that the patient must give prior written consent to the PA's performing medical services on an annual basis or as often as the patient is

treated by a new PA. The requirement for patient consent appears to be unique to PAs, and it is conceivable that this, too, will cause a "chilling" effect on patient response inasmuch as patients may question why consent is needed for PA services when it is not required for other health workers. Physicians, too, are likely to regard the consent requirement as an unnecessary and unreasonable administrative burden, considering the attention that must be given to maintaining current, signed consent forms. In most states, PAs are also required to wear name tags or display appropriate certificates which clearly identify them as being a physician assistant. This name-tag requirement may serve the same purpose as patient consent for PA services because the PA is clearly identifiable. If the patient objects to being cared for by the PA, he can inform the SP.

Requirements for Assistants to the Specialist Physician

Only a small number of PA laws and regulations address the situation of PAs working under the supervision of *specialist* physicians. The New York law authorizes the use of PAs by specialist physicians, and regulations for the orthopedic and urologic assistant are now being prepared by that state's commissioner of health and commissioner of education, who have joint responsibility for promulgating PA rules. California, too, has developed regulations for the assistant to the orthopedic surgeon and the assistant to the emergency care physician, in addition to its detailed requirements for the assistant to the primary care physician. The South Dakota law permits the assistant to the specialist physician to perform some of the same duties as the assistant to the primary care physician as well as any other specialized tasks for which training and proficiency can be demonstrated. (no PA regulations have as yet been developed in South Dakota.) In contrast, the Washington regulations, patterned after the typology advanced by the National Academy of Sciences (1970), suggest that the assistant to the specialist physician is *less* skilled and is qualified to perform only certain specialized tasks because he *lacks* the more general training and experience attributed to the assistant to the primary care physician.

Although not addressed either in the PA laws or regulations in most other states, it is certainly arguable that under their broad mandate to sanction PAs, state regulatory agencies have the authority to approve assistants to specialist physicians. This may be accomplished administratively in most states by requiring the PA and specialist SP to prepare a description of duties to be performed by the PA. This job description could then be evaluated with regard to the PA's *specialized* training and experience.

Continued Competence

Although about half of the PA regulations explicitly require renewal of the PA's approval on an annual basis, most of these provisions merely stipulate payment of a renewal fee. Thus, as generally the case with other state-regulated categories of health manpower, re-registration is but a *pro forma* and routine process that does not involve any substantive review of the applicant's competence or performance. Inasmuch as state regulation of PAs is such a recent phenomenon, this is even more disturbing because it fails to take into account the growing concern for assurance of *continued* competence as opposed to *one-time*, initial entry competence. At a time when many of the older and more established health professions, e.g., medicine, dentistry, and nursing, are being required by states to satisfy certain basic, albeit tentative, measures of continued competence, such as continuing education, it would have been opportune for the states and, specifically, the medical profession to build into the PA credentialing process the rudiments of a meaningful renewal process that incorporated a review of the PA's performance, development, and continued capacity to function.

In this context, it is of interest to point out five different approaches to this problem that suggest at least some concern in the states with the issue of continued competence. The California regulations require that evidence be provided in the initial application for PA approval that both the SP and the PA are involved in a continuing education program approved by the state board of medical examiners. Oklahoma requires that prior to renewal of a PA's approval, there must be a review of the PA and the SP and his

practice. An important component of the Vermont renewal process is the required certification by the SP that the previous year's performance of the PA was satisfactory. In Arizona and Oregon, upon termination of employment of a PA, the SP is required to submit a summary of reasons for, and circumstances of, termination of the PA's employment. This suggests an interest on the part of the state to examine the actual performance of the PA, and presumably this information would be utilized in any subsequent approval of that particular PA.

Arizona and Oregon also have provisions that require the SP to furnish reports, as required by the board, on the performance of the PA. It is not clear, however, if this report is to be submitted on a periodic basis or if the provision even extends to all SPs, or only to those SPs of whom the board specifically makes such request.

In Washington, the SP must submit together with the renewal application a current statement of utilization, skills, and supervision of the PA. In addition, the Washington regulations contain the provision "that the board will grant specific approval for tasks which may be performed by the assistant based upon the curriculum of the program from which the assistant graduated." However, requests for approval of newly acquired skills may be considered at any regular meeting of the board of medical examiners. Thus, any request by the SP for approval of additional task delegation would probably initiate a re-examination of the PA's qualifications. Moreover, in the event that a currently registered PA, in Washington, desires to become associated with another physician, such transfer may be accomplished administratively with approval of the chairman of the board of medical examiners, providing that the new SP is licensed and in good standing in the state and that evidence is submitted to document the continued competence of the PA.

Thus, while only a handful of states have provisions in their regulations that address the continued competence of PAs, there are at least a few good examples of this concern in the state regulations. These approaches should be evaluated, however, to determine whether they do, in fact, guarantee a minimum standard of competence. In this way, those approaches to continued assurance of PA competence that appear to have the greatest impact upon quality should be adopted by the other states. Clearly, this is an

area of evaluative research that might have very dramatic results on the developing credentialing policy on physician assistants.

Disciplinary Authority

Disciplinary action can be taken against either the PA or his SP. Most of the regulations list all or most of the following grounds for revoking, suspending, or placing on probation PA approval: representing himself or permitting another to represent him as a physician; practicing beyond the scope of his authority or job description; habitually using intoxicants or drugs to the extent that he is unable to safely perform his duties; being convicted of a felony or criminal offense involving moral turpitude; suffering from a mental condition which makes him incapable of safely performing his duties; or failing to comply with the laws and regulations pertaining to PAs.

Although most of the PA regulations do not specifically address the question of what constitutes grounds for discipline of the SP with respect to his employment and supervision of the PA, state boards of medical examiners apparently have ample authority under the medical practice acts to take disciplinary action against the SP if he were to be found guilty of illegal or unethical conduct relating to employment and utilization of the PA. Several recent reports and studies, however, have argued, on the basis of the scant number of disciplinary actions reported, that agencies responsible for discipline of physicians and other health professionals have not discharged this responsibility very effectively (U. S. Department of Health, Education, and Welfare, 1971: 31-33; Cohen, 1973b; Derbyshire, 1974). The diverse educational backgrounds, experience, and employment settings of PAs coupled with the current lack of appropriate information about their effect on the health care system would make it imperative that state regulatory agencies fully discharge their monitoring and disciplinary functions pertaining to PAs and SPs in order to provide adequate protection of the consumer.

Several of the PA regulations contain unique grounds for disciplinary action. For example, the Alabama regulations provide that a physician may have his right to employ a PA withdrawn if he

"has done or caused to be done any act which brings discredit to the medical profession and/or the 'Assistants to the Physicians' Program." This provision certainly follows the tradition noted by Cohen (1973b:53-54), of incorporating unusually vague and ambiguous terminology in the disciplinary requirements of professional practice acts. Another unique ground for disciplinary action is the California provision mandating that the SP and PA meet certain continuing education requirements; otherwise, the state may withdraw its approval of the PA to practice and of the SP to employ an assistant.

Conclusions

Although there is no agreement on the precise role of the PA in delivery of health services, recent studies (Nelson et al., 1974) suggest that patient acceptance of PAs is quite favorable. Such consumer reaction, if sustained, as well as the growth of federal assistance for PA training as one of several strategies to address the problem of medically underserved areas, will probably result in a significant increase in the production and utilization of PAs. Accordingly, regulatory agencies may face growing pressure to promulgate rules that will permit the most effective use of this new category of health manpower. The major pattern of PA legislation has been the granting of regulatory power to state boards of medical examiners, which would suggest continued reliance upon the customary regulatory mechanisms of health manpower. However, our analysis of the regulations already formulated by these agencies indicates very little consensus on the best model of quality assurance. In fact, the diverse nature of present PA regulations exemplifies the generally pluralistic system of state policy in the absence of federal legislation.

The diversity of PA regulatory policy among states raises an important question—should a national credentialing program be established? Given the significant maldistribution of health manpower in the country and the great variability in the training and utilization of PAs, it is appropriate that state agencies continue to have primary responsibility for PA approval. This type of decentralized control would facilitate the continued demonstration of expanding PA roles and competencies, especially in remote settings

where direct supervision is impractical. Flexibility, therefore, must be the basic premise of any PA regulatory system.

While it is difficult to point to any of the PA regulatory schemes already developed as a model or ideal-type for regulating PA performance, given the unique and changing scope of this discipline, there are certain elements which, in our opinion, should be adopted universally: First, provision should be made to accept an application for approval from anyone who has passed the national certification examination developed by the NBME. This is based upon our expectation that the examination will undergo continual study and revision to reflect changes in the training and utilization of the PA.

Second, the employing physician should be required to provide a job description for the PA. This description of PA duties, similar in many respects to a contract, can then be reviewed in terms of the training and qualifications of both the PA and his SP as well as the type of medical practice involved. This approach offers a flexible and realistic means of regulating the PA. The SP, after all, bears the ultimate onus of responsibility in the event of any errors of omission or commission, and can be expected to exhibit appropriate care in preparing the job description for review by the state regulatory agency.

Third, the PA supervisory requirements should remain flexible and should be dependent upon the unique qualifications of the individual PA and the setting in which he works. There are numerous places in the country where it is necessary and appropriate to have PAs practicing in remote settings without direct, over-the-shoulder supervision. State regulations should permit such activity where proper safeguards are provided.

Finally, PAs should be required to demonstrate their continued competence on an annual basis, through performance ratings by their employing physicians, examinations, or some other evaluative mechanism that addresses the PA's performance.

These requirements, which are being implemented in a number of states, undoubtedly will place a growing burden on the present resources of state regulatory agencies. If these agencies are to perform their legislatively mandated functions, they must receive adequate financial support. Unfortunately, in some states, these responsibilities have been imposed upon the boards without

any additional resources. This situation is inconsistent with the notion of accountability and responsibility inherent in any public agency, and certainly in a state board of medical examiners with its dramatic impact on the health and safety of the public. This brings us full circle to the issue of implementation touched upon at the outset of the paper. Without the necessary resources to administer a PA regulatory program, even the most elaborate administrative rules may have little bearing on the *actual* pattern of implementation.

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