STATE LEGISLATION FOR PHYSICIAN'S ASSISTANTS

A REVIEW AND ANALYSIS

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Interest in the use of physician's assistants (PAs) as a partial solution to problems created by shortages of skilled health manpower continued to increase throughout 1972. This interest was reflected by the dramatic increase in the number of PA training programs during the year, as the Federal Government provided expanded financial assistance for program development and student support.

The rapid expansion of educational programs and the increasing number of PAs becoming available for employment have caused concern among employers, educators, health manpower experts, lawyers, and PAs that changes in State laws and regulations may be necessary to legally recognize and accommodate this new category of health personnel. These changes are mandated because many PAs are capable of performing tasks heretofore considered solely within the province of physicians. This article reviews the present statutory status of PAs.

By the end of 1972, legislation pertaining to PAs had been enacted in 24 States—Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Iowa, Kansas, Maryland, Montana, New Hampshire, New York, North Carolina, Oklahoma, Oregon, Utah, Vermont, Washington, and West Virginia. Also, the legislatures had considered but rejected a variety of PA proposals in 15 other States—Hawaii, Illinois, Indiana, Kentucky, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, and Wisconsin. The legislatures of the remaining 11 States had not entertained any PA bills. Thus, most State legislatures have considered PA legislation, and nearly half have enacted some type of law permitting physicians to delegate medical tasks to assistants.

Types of Legislation Enacted

An analysis of State laws shows that two distinct statutory forms are used to grant legislative sanction to physician's assistants—the general delegatory statute and the regulatory authority statute (see table).

General delegatory statute. This statutory form simply amends the State medical practice act and permits PAs to work under the supervision of physicians. It is illustrated by the Connecticut law (Conn. Gen. Stat Ann. sec. 20–9 (1971)) which states:

> 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 a licensed practical nurse if such service is rendered under the supervision, control, and responsibility of a licensed physician.

Analysis of legislation for physician's assistants in 24 States

State	Type of law	Regulatory agency	Power to make rules	Approval of PA	Job description	Activities prohibited	Certification renewal	PAs per physician	Education program approved	Approval of MD	Report to legislature
Alabama	Regulatory authority, 1971	Board of medical examiners	Yes	Yes	Yes	Optometry			Yes	Yes	
Alaska	General delegatory, 1972										
Arizona	Regulatory authority, 1972	Board of medical examiners, board of osteopathic examiners	Yes	Yes		Chiropractics, dentistry, optician's services, naturopathy, optometry, pharmacy					
Arkansas	General delegatory, 1971					Optometric services					
California	Regulatory authority, 1970	Board of medical examiners	Yes	Yes	Yes	Dentistry, dental hygiene, optometry	Annual	2	Yes	Yes	1972
Colorado	General delegatory, 1963										
Colorado	Regulatory authority, 1969	Board of medical examiners	Yes	Yes		Pharmacy	Annual	1	Yes	Yes	1977
Connecticut	General delegatory, 1971					Dentistry, dental hygiene, optometry					
Delaware	General delegatory, 1971					Optometry					
Florida	Regulatory authority, 1971	Board of medical examiners	Yes	Yes	Yes		Annual	2	Yes	Yes	1973
Georgia	Regulatory authority, 1972	Board of medical examiners	Yes	Yes	Yes	Pharmacy		2	Yes	Yes	
Idaho	Regulatory authority, 1972	Board of medical examiners	Yes	Yes		Pharmacy, dentistry, dental hygiene, optometry			Yes	Yes	

Iowa	Regulatory authority, 1971	Board of medical examiners	Yes	Yes	Yes	Optometry	Annual	2	Yes	Yes	1973
Kansas	General delegatory, 1964										
Maryland	Regulatory authority, 1972	Board of medical examiners									
Montana	General delegatory, 1970										
New Hampshire	Regulatory authority, 1971	Board of medical examiners	Yes	Yes		Optometry, optician's services					
New York	Regulatory authority, 1971	Commissioner of health, commissioner of education	Yes	Yes			Biennial	2	Yes		
North Carolina	Regulatory authority, 1971	Board of medical examiners	Yes	Yes			Annual	2	Yes	Yes	
Oklahoma	Regulatory authority, 1972	Board of medical examiners	Yes	Yes		Optometry			Yes		
Oregon	Regulatory authority, 1971	Board of medical examiners	Yes	Yes	Yes	Optometry, nursing, dentistry, dental hygiene	Annual	1	Yes	Yes	1973
Utah	Regulatory authority, 1971	Medical association							Yes		
Vermont	Regulatory authority, 1972	Agency of human services	Yes	Yes							1975
Washington	Regulatory authority, 1971	Board of medical examiners	Yes	Yes	Yes	Optometry, dentistry, dental hygiene, chiropractic services, chiropody	Annual	1	Yes	Yes	
West Virginia	Regulatory authority, 1971	Medical licensing board	Yes	Yes	Yes	Pharmacy, optometry	Annual		Yes	Yes	

Of the 24 States which have passed PA laws, Alaska, Arkansas, Colorado, Connecticut, Delaware, Kansas, and Montana have general delegatory statutes, with wording only slightly different from that of the Connecticut law.

Regulatory authority statute. Eighteen State legislatures (Alabama, Arizona, California, Colorado, Florida, Georgia, Idaho, Iowa, Maryland, New Hampshire, New York, North Carolina, Oklahoma, Oregon, Utah, Vermont, Washington, and West Virginia) have enacted laws which authorize a specific organizational entity, usually the State board of medical examiners, to establish rules and regulations with respect to the educational and employment qualifications of PAs. This type of statute is referred to as a regulatory statute because it gives power to some agency to regulate many activities pertaining to PAs.

Colorado has both a general delegatory statute (Colo. Rev. Stat. Ann. sec. 91–1–6(3)(m) (1963)) and a regulatory authority statute (Colo. Rev. Stat. Ann. sec. 91–10–3 (1969)). The regulatory statute, referred to as the Child Health Associate Law, provides detailed requirements for PAs employed by physicians who work primarily in pediatrics, and it is the only PA statute which actually establishes licensure requirements. The pros and cons of the Colorado Child Health Associate Law have been discussed by Silver (*1*) and Curran (*2*).

Advantages and Disadvantages

General delegatory statutes. Several arguments for general delegatory statutes, such as that of Connecticut, have been made by those who have investigated ways by which the PA can best be granted legal status as a member of the health team. One argument is that physicians employing PAs are likely to use them for a wide variety of tasks, and they should not be restricted in their task delegation by detailed statutory provisions. This proposal is particularly important in view of the great deal of experimentation to determine which medical tasks are appropriate for nonphysicians. Rigid statutory requirements, arguably, would retard such potentially valuable experimental efforts (*3*). Moreover, the general delegatory statute is an alternative to the enactment of specialized licensure laws, which has caused much concern in recent years (*4*). Because of this concern, the Department of Health, Education, and Welfare recommended a moratorium on further licensing of new health occupations in a recent report (*5*).

An important issue in discussions of the evolution of a new category of health worker is how the patient will be protected from incompetent practitioners. Persons in favor of general delegatory legislation say that the patient's safety will be insured because the physician has supervisory authority over the PA and thus would be liable for any malfeasance by the PA. Under the threat of this liability, the physician will employ qualified assistants and will maintain close surveillance and supervision, thus assuring adequate protection for the patient (*3a*).

General delegatory statutes, however, do present certain problems. Since no provisions are made for approving courses of study for PAs, physicians may employ anyone in this role, regardless of training and experience, and legally delegate a wide variety of medical tasks to that employee. Consequently, the general delegatory power places much responsibility on the individual physician because he has inadequate guidelines to determine (*a*) the activities he should delegate and (*b*) the qualifications the PA should possess to insure competence in performing specific activities.

The argument that because of his potential liability a physician will be restrained from employing an unqualified person or from abrogating his supervisory responsibilities is theoretically good. However, in areas where there is a substantial shortage of medical personnel, the demand for services may become so great that a physician may feel compelled to risk hiring anyone who can provide assistance; subsequently, the pressures of practice may well prohibit the physician from supervising that employee.

Additionally, the absence of clear and definitive guidelines on qualifications for PAs may possibly deter many physicians from using PAs. Such a response would be counter-productive of the raison d'etre of general delegatory statutes—to provide a mechanism for relieving physicians from routine medical tasks so that they have more time for more demanding functions.

Another disadvantage of this statutory approach is lack of official recognition of the PAs. According to some observers, without formal recognition inherent in certification or licensure, the PA profession may be deprived of certain status factors.

Regulatory authority statutes. An overwhelming majority of the State legislatures enacting PA laws were not satisfied with the general delegatory

statute which gives physicians sole responsibility for determining educational qualifications and job assignments. These legislatures passed more detailed laws, granting a specific organizational entity—usually the State board of medical examiners—authority to establish rules and regulations relating to the education and employment of PAs.

While each of these statutes provides a mechanism for regulating the training and employment of PAs, collectively they include a broad range of provisions relating to the duties of the boards of medical examiners, accreditation of educational programs, and certification of assistants and their employers. Several of these laws (for example, Arizona, Idaho, Maryland, North Carolina, and Oklahoma) are amendments to the medical practice acts, differing from the general delegatory statute only in that they designate an organizational body to make all rules and regulations pertaining to PAs. At the other end of the spectrum, several statutes include much detail regarding the education, experience, employment, and duties of the PA and the employing physician (the Colorado Child Health Associate Act is a prime example).

While a law which gives a regulatory agency rule-making power reduces somewhat the flexibility inherent in the general delegatory statute, it does have several advantages. It provides more protection to patients because the PAs must meet certain minimum educational and skill requirements before they can be approved for employment.

Another advantage is that only graduates of approved training programs are permitted to practice. The regulatory statute also enables physicians to clearly understand the requisite qualifications of an assistant, making it easier to identify and retain persons who have such qualifications.

Further, by granting regulatory authority to an administrative agency, rules and regulations can be amended to reflect new knowledge about PAs without having to seek changes in State legislation which may involve protracted procedural and political difficulties. Finally, such regulatory authority vested in an agency makes it possible to keep abreast of the number, specialties, qualifications, and duties of PAs, thereby facilitating evaluation of their contribution to the delivery of health care.

The regulatory approach, however, also has disadvantages. One prevalent disadvantage is that many State boards of medical examiners lack the expertise or resources to develop and conduct examinations for applicants or to perform accreditation functions relating to training programs; thus, such boards may be hampered in attempting these tasks. Another potential drawback is that the boards may set varying educational and experience requirements, and this lack of uniformity may greatly hinder the geographic mobility of PAs.

Several State statutes (for example, California and Florida) call for the development, if feasible, of equivalency and proficiency tests enabling persons with certain skills and experience to gain certification, even though they may lack the usual formal educational requirements. Because of inadequate resources, however, most boards will have difficulty in developing these equivalency and proficiency tests. Moreover, a relatively small number of PAs will be practicing in the near future in many States, making the development of valid tests even more difficult.

Board Approval of PAs

As previously mentioned, a number of the regulatory authority statutes give almost complete discretion to the boards of medical examiners to establish rules and regulations pertaining to PAs.

Because of a lack of relevant staffing and experience, most boards have been slow to develop regulations, but where they have been developed the regulations, of course, have the force of law. In this discussion of the provisions of the regulatory authority statutes, regulations are considered equivalent to legislation.

The primary prerequisite for a PA to be approved by the board is the satisfactory completion of an accredited educational program. Both legislators and members of the boards typically rely heavily on accreditation of educational programs as the most efficient and reliable method of insuring the competence of PAs. The theory, presumably, is that high quality educational programs will produce graduates with the basic knowledge and skills necessary to perform at an acceptable level.

To further protect patients from incompetence eight States (Alabama, California, Florida, Georgia, Iowa, Oregon, Washington, and West Virginia), either by legislation or regulation, require the physician and his proposed assistant to submit to the board for approval a job description outlining the way the PA is to be used. Presumably, boards in other States with PA laws would also have the power under their regulatory authority to require job descriptions.

Requiring job descriptions is an excellent way to regulate PA activities because the description must be geared especially to the training and experience of the applicant, and it also forces the physician to plan carefuly how he will use his assistant.

The required use of job descriptions, however, is not without potential problems. Should an assistant exceed the bounds of his job description, he could lose his certification by the regulatory authority and face criminal charges for his actions. Moreover, in civil suits, evidence of such unauthorized activity may give rise to an inference of negligence. Another common requirement in both legislation and regulations is that the applicant be of good moral character, and many boards reserve the right to investigate in detail the character of an applicant (*6*).

Only the Child Health Associate Law of Colorado specifically requires that an applicant undergo an oral or a written examination before being certified. But this act, as noted previously, is clearly modeled after the practice acts of other categories of health manpower. This act also differs sharply from the two models discussed in this paper—the general delegatory and the regulatory authority statutes. Nevertheless, under their broad regulatory authority, boards appear to have the power to require applicants to take such examinations if they are deemed important in determining whether the PA has the basic knowledge and skills to perform his duties.

Age limitations are specified by only three States—Colorado, New York, and West Virginia. Each of these States requires that applicants be at least 21 years of age. Fees for applicants, where specified, range from $5 to $50. Most of the statutes empower the board to charge "reasonable" fees for processing applications.

A PA can lose his certification for a variety of reasons—presenting himself as a physician, practicing beyond the scope of his authority or his 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 physician's assistants (*7*). Enforcement of these provisions should be no less problematic than enforcement of similar provisions in the practice acts of other health practitioners, which appear in the "Report on Licensure and Related Health Personnel Credentialing" (*5*).

Functions Prohibited to PAs

Several groups of health professionals have expressed concern that State approval of PAs would allow them to perform tasks previously within the sole province of other licensed health personnel. The major fear is that physicians may delegate to assistants many functions previously considered to be within the province of other health professions, resulting in a declining need for certain specialized categories. As a consequence of this concern, some professional groups have incorporated provisions in legislation prohibiting the PAs from performing certain duties. In several States this political activity has been intense, and it has led to the defeat of PA proposals introduced in some legislatures.

The optometric associations have been most active in efforts to limit PA functions. They have successfully promoted clauses prohibiting PAs from providing optometric services in the PA statutes of 10 States—Arizona, California, Connecticut, Delaware, Idaho, Iowa, New Hampshire, Oklahoma, Oregon, and Washington.

The Alabama PA statute states that an assistant can perform optometric services only under the "direct, personal, physical presence" of a physician (Ala. House Bill No. 1151 (enacted Sept. 20, 1971)). In West Virginia an ophthalmologist is not permitted to use a PA for any purpose (W. Va. Code Ann. sec. 30–3A–1 (1971)).

Some health manpower experts say that the optometrists' concern and political activity stem from recent technological breakthroughs which permit eye refractions and eyeglass prescriptions to be determined by sophisticated mechanical devices. This new technology, it is suggested, may threaten the existence of professionally trained optometrists.

Other groups are also seeking to restrict the scope of PA functions. Six statutes prohibit PAs from practicing dentistry (Arizona, California, Connecticut, Idaho, Oregon, and Washington); five from practicing dental hygiene (California, Connecticut, Idaho, Oregon, Washington); five from practicing pharmacy (California, Connecticut, Idaho, Oregon, and Washington); and two from practicing chiropractics (Arizona and Washington).

In the New York statute, the language pertain-

ing to PA functions is ambiguous. It declares that PAs cannot perform functions which are specifically delegated by law to allied health professionals licensed under the public health or the education laws (N.Y. Pub. Health Law sec. 3701 (1971)). It does not spell out how the delineation is to be made.

Maryland has perhaps the most ambiguous law, which may well raise several administrative problems. The statute provides that if the functions to be delegated to a PA are within the scope of practice of categories already licensed, the board of medical examiners and the agency representing the other licensed category must issue joint regulations on the matter; if they cannot agree on these regulations, the State department of health and mental hygiene is given the power to arbitrate the differences (Md. House Bill No. 468 (enacted May 31, 1972)). Since PAs conceivably will be delegated tasks that are within the scope of practice of several other licensed professions, the Maryland law may necessitate the development of a series of joint regulations—a tedious and difficult process.

Supervision of PAs

Of the many questions raised about employment of PAs, one of the most important and difficult to answer is the amount and type of supervision they should receive. Opinions of health manpower experts vary widely on this issue. Some experts contend that because the PAs receive a relatively brief period of formal training, the employing physician should be required to provide over-the-shoulder supervision. Others say the PA should be given more responsibility and should be permitted to perform the tasks for which he is trained and qualified if he can communicate with the physician in some manner should the need arise.

A review of the 24 statutes permitting the use of PAs reveals that a physician can adopt any one of the supervisory approaches mentioned, depending on the State in which he practices, and still be within the law. While all the statutes call for some degree of supervision, their varying terminology is subject to varying interpretations.

The general delegatory statute usually requires that the PA will render service "under the supervision and control" (Ark. Stat. 53–1 (1971)) of a licensed physician. Since this form of statute does not grant any agency the authority to regulate the use of PAs, the responsibility for interpretation of the law rests with the individual physician, and, if his interpretation is challenged, the courts.

It seems clear that such statutory language will be enough, assuming no further clarification, to hold that the physician is responsible and liable for the acts of his assistant under the master-servant doctrine expounded by the courts. However, the actual extent of control and supervision required is debatable. It is possible that while a physician would be ethically irresponsible in employing a large number of PAs—setting them up, for example, in satellite clinics and maintaining telephone linkage with them—he may not be legally liable. Although this situation is probably unlikely, because of the potential for civil liability, no court decisions have yet been made on this issue and in many States the question is still debatable. Conceivably, if the potential rewards are great enough, a physician might be willing to incur certain risks.

To avoid this problem, six States (California, Florida, Georgia, Iowa, New York, and North Carolina) allow the physician to supervise a maximum of two PAs, while three (Colorado, Oregon, and Washington) permit only one PA per physician. (In Washington a physician can supervise more than one PA if authorization is obtained from the Washington State Board of Medical Examiners.)

Several statutes suggest that direct, over-the-shoulder supervision by physicians is not required. In Alabama, for example, the law states that a PA must perform medical services under the "supervision" of a licensed physician. In the same paragraph, however, the statute states that if any of those medical services usually associated with the practice of optometry are to be performed by a PA, he must perform them under the "physician's direct, personal, physical supervision" (Ala. House Bill No. 1151 (enacted Sept. 20, 1971)); thus, it may be inferred that such supervision would be required only for optometric services. Whether this inference is strong enough to support the proposition that a PA can be legally supervised by telephone communication remains debatable.

Some of the more detailed PA statutes approach the supervision question in a different way. For example, the Georgia law states that a PA "shall be allowed to perform his duties only in the principal offices of the applying physician" (Ga. House Bill No. 1592 (enacted March 31, 1972)).

Although some exceptions, such as making house calls and hospital rounds, are made to this provision if the PA is qualified, it appears that the intent of the wording is to insure that the supervising physician is at the place where the PA is rendering service.

Other States have more precise definitions of "supervision," as in the Florida law in which supervision, except in emergencies, "shall require the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician's assistant (Fla. Stat. Ann. sec. 458.135 (supp. 1971)).

Legislatures in other States have simply delegated the definitional problems to the regulatory body governing the activities of PAs to develop regulations concerning what is meant by "supervision."

Approval of PA Training Programs

Only three States (Colorado, Florida, and New York) have specified the length of educational programs for PAs. The remaining 15 States which have enacted regulatory authority statutes give complete discretion for approving programs to the board of medical examiners or other appropriate body.

The Child Health Associate Law of Colorado has by far the most stringent educational requirements. This law requires that to be approved a training program must lead to a bachelor's degree plus 1 year of clinical internship. The law also lists the subject matter to be taught in child health associate training programs (Colo. Rev. Stat. Ann. sec. 91–10–3 (1969)). In Florida, the statute declares that a PA must attend a training program that lasts at least 24 months (Fla. Stat. Ann. sec. 458.135 (supp. 1971)). The New York Statute, on the other hand, states that any PA training program must include a minimum of 32 credit hours of classroom instruction and 40 weeks of supervised clinical training (N. Y. Pub. Health Law sec. 3701 (1971)). Neither the Florida nor the New York law specifies the subject matter to be covered.

Under their regulatory authority, several boards of medical examiners have addressed the issue of standards for educational programs. In North Carolina (*6*) and West Virginia (*7*), the regulations state that a training program must be for at least 2 academic years and must be sponsored by a college or university, with appropriate arrangements made for clinical training of the students.

While Oregon's regulations do not specify a minimum length for training programs, they do require that the PA must have completed a training course at a school of medicine (*8*). The board of medical examiners in California has established requirements for training programs including subjects that must be taught, although the minimum length of the program is not specified (*9*).

The boards in several States have apparently sought to maintain control of training programs by requiring that they be sponsored by colleges and universities, thereby excluding the establishment of proprietary programs set up exclusively for training PAs.

While only one PA law specifies continuing education requirements—the Child Health Associate Law of Colorado requires 14 hours per year of postgraduate studies for license approval (Colo. Rev. Stat. Ann. sec. 91–10–3 (1969))—presumably all the boards have authority to set such requirements for continued approval under their broad mandate to regulate and approve training programs and to certify PA applicants.

Board Approval of Physicians Using PAs

As a further control on the employment of PAs, the laws of 12 States require the board of medical examiners to approve the physicians who employ PAs (Alabama, California, Colorado, Florida, Georgia, Idaho, Iowa, North Carolina, Oregon, Vermont, Washington, and West Virginia). In Vermont the physician must certify the statements of a PA applicant relating to his employment. On this point, the provisions of the Alabama statute are fairly typical. The law states that a physician seeking to employ a PA must submit to the board an application which lists (*a*) background and specialty of the physician, (*b*) qualifications and experience of the proposed assistant, and (*c*) a description of the physician's practice and the way in which the assistant will be used (Alabama House Bill No. 1151 (enacted Sept. 20, 1971)). The board is then empowered to judge whether the physician is suitable and competent to supervise a PA.

Illegal Practice of Medicine

The legal issues regarding PAs are complex and have evoked much controversy. Of major concern are the legality of delegating tasks to nonphysicians and problems associated with malpractice.

In any of the 26 States without an authorizing statute, the practicing PA conceivably could be

indicted for the illegal practice of medicine, and his employing physician could be charged with aiding and abetting the illegal practice. Although this type of indictment is not probable, a few disquieting legal precedents indicate the need for statutory recognition of the PA. The most quoted case on this subject is Whittaker v. Superior Court of Shasta County, 438 P. 2d 358 (Cal. 1968), in which a former medical corpsman, acting as a surgical assistant, was convicted of practicing medicine without a license for operating a cranial saw during brain surgery. His supervising physician was also found guilty of aiding and abetting the illegal practice of medicine. (This case was decided before the passage of the California PA law.)

If a PA is charged with illegal practice of medicine in a State which has no PA statute, his chief defense would likely be the doctrine of "custom and usage." Basically, this argument is that physicians have so often delegated certain medical tasks to assistants that the delegation was considered good and acceptable medical practice in that particular jurisdiction. Even if the courts were to recognize the doctrine of custom and usage, physicians may nonetheless be reluctant to delegate the more advanced procedures which the PA is qualified to perform. This possibility would preclude the PA from being used to his maximum capacity and would reduce the value of his training and employment.

Negligence Actions

Where there is no statutory sanction of PAs, problems may be encountered in negligence actions brought against the PA. The primary example is Barber v. Reinking, 411 P. 2d 861 (Wash. 1966), in which the plaintiff was injured when a licensed practical nurse administered an injection and the needle broke. Since only physicians and professional registered nurses are permitted to give injections in the State of Washington, the court held that one who undertakes to perform the services of a RN must have the knowledge and skill of a RN, and the defendant's failure to be properly licensed raised an inference of negligence. Obviously, this placed a heavy burden of proof on the defendant. The preceding case, as well as others, indicates that some courts may rigidly interpret the medical and nurse practice acts and rule against a defendant regardless of his professional qualifications or of the doctrine of custom and usage. This ambiguity could directly result in constraints on the employment and use of PAs, and it provides further reason to enact appropriate legislation in States which have not yet legitimized the PA.

Nurse practitioners, on the other hand, are less likely to encounter the kinds of legal difficulties described because they are largely covered by the nurse practice acts. The wording of some of these acts is exceedingly ambiguous, however, and efforts should be made to revise and expand such acts for the purpose of defining more clearly the roles and responsibilities of all forms of nursing.

Standard of Care

Although PAs are formally recognized in numerous State statutes they, as other health practitioners, still risk being sued for malpractice. Malpractice litigation, of course, is a civil action in which the plaintiff claims that the defendant did something he should not have done or did not do something he should have done (*10*).

Whether a PA was in fact negligent is a question for the court to determine, and it seems that the standard of care by which the PA will be judged is the same standard of skill, knowledge, and care used to evaluate physician performance. This type of judgment results from the presumption that a patient consulting with a physician in the first instance would expect that if a medical procedure is delegated to another person that person would have the same degree of knowledge and skill as the physician, according to an unpublished paper written in May 1972, by Roger M. Barkin, MD, entitled "The Law and the New Health Professional," page 63. While there have been no decisions as yet involving PAs on this particular point, many judicial opinions dealing with other categories of health personnel substantiate this proposition.

Because of the lack of legal precedent specifically involving PAs, no definitive statement can be made at this time concerning what standard of care would be used to judge their conduct. At least one author (*11*) has suggested that it might be more advantageous to the concept of task delegation if the PA were held to the standard of care of the "ordinary PA" practicing under similar circumstances. Regardless of which standard is used, there probably will be little reduction in the quality of care required by tort law.

Legal Liability of the Physician

The supervising physician may also face a suit for the actions of the PA, based on two major

grounds. First, the physician may be guilty of negligence if he delegated a task which he knew or should have known was beyond the PA's competence. In Delaney v. Resenthal, 196 N.E. 2d 878 (1964), a physician permitted an inexperienced nurse to treat a patient's thumb injury, which later developed into osteomyelitis. The physician was held liable for this delegation because he had inappropriately authorized an unqualified person to perform functions which should have been delegated to an experienced nurse or physician (Barkin, page 62).

Another legal doctrine which may be used to hold physicians liable for the malfeasance of their PAs is *respondeat superior*. Under this doctrine, the physician is deemed by law to be responsible for the acts of his assistant even though the physician himself is in no way negligent. One purpose of the doctrine is to encourage physicians to maintain adequate supervision of their employees, while another is to provide the plaintiff a financially responsible party to sue. Since the language of every PA statute stipulates that the PA will work under the direction, supervision, and control of the physician, the legislative basis for employing this doctrine clearly exists.

Because *respondeat superior* is recognized and accepted in most jurisdictions, some authorities say that it will deter physicians from hiring PAs. Moreover, even if both the physician and the PA have malpractice insurance—which, of course, decreases the financial risks—physicians fear malpractice suits for several important reasons, including the potential loss of reputation and good standing in the community (*11a*). In this connection, at least one State legislature (Cal. Assembly Bill No. 976 (introduced May 4, 1972)) has entertained a bill making the PA solely responsible for his wrongful acts. As more PAs are trained, it will be important to determine if their employment prospects are seriously threatened by the application or potential application of the doctrine of *respondeat superior*.

The potential of malpractice litigation involving PAs has not limited the ability of PAs or their employers to obtain malpractice insurance. The companies providing malpractice insurance have readily offered expanded coverage to physicians employing PAs and separate policies for the PAs themselves.

Conclusion

From this review of some of the potential problems associated with the employment of physician's assistants, it is evident that all States should consider enacting legislation that will permit physician's assistants to be utilized to their greatest capacity. Equally important is the need for those States which have passed legislation to evaluate the utilization of PAs under the law and to make amendments where appropriate. In this evaluation, the interests of all parties involved—consumers, employers, educators, physician's assistants, and other health professionals—should be considered.

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