RESUME OF PROCEEDINGS AT MEETING ON
LEGISLATIVE PROPOSAL FOR
PHYSICIAN'S ASSISTANTS

2:00 p.m. March 1, 1970

On Sunday, March 1, 1970, a meeting was held in Durham, North Carolina, as an intermediate step in a project sponsored by the Department of Health, Education and Welfare* to develop a legislative proposal under which physician's assistants could be accommodated into the legal framework of health care delivery in North Carolina and in other states similarly situated. The project was formally initiated in October 1969, with a two-day conference attended by interested physicians, nurses, and lawyers from within the state as well as by several legal consultants from other states. The objective of that conference was to provide a forum for discussion of the problems raised by the introduction of new types of manpower into the traditionally license-oriented health industry and the various alternative means whereby these problems could be resolved. After a discussion of the merits and disadvantages of several alternatives, including licensing physician's assistants, specially licensing physicians utilizing physician's assistants, and establishing a Committee on Health Manpower Innovations to control the development and utilization of new personnel, it was the consensus among those assembled that the best approach would be the enactment of an exception to the Medical Practice Act, specifying that acts performed by a trained assistant under the direction and supervision of a licensed physician should not be construed as within the prohibited unlicensed practice of medicine. Similar statutes are currently in force in Arizona, Colorado, Kansas, and

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* This project is being conducted under Contract No. HSM 110-69-242.

Oklahoma.

From the standpoint of the physician and his assistant, it is felt that such an exception would reduce the risk of criminal prosecution for the unlicensed practice of medicine by the assistant and for aiding and abetting by the physician, as long as the tasks delegated are in fact supervised by the physician. It was also anticipated that the statute would preclude the drawing of an inference of negligence in a civil suit from the mere delegation of tasks to or the performance of tasks by unlicensed personnel. It was felt that liability should inhere only on a showing of actual negligence, either on the physician's part, in delegating to an assistant he knew or should have known was not competent to perform the task delegated, or on the assistant's part, as demonstrated by his failing to satisfy the requisite standard of care in performing the task. In the event actual negligence could be established, the assistant would continue to be liable to the injured patient, and the physician would continue to be vicariously liable under the doctrine of respondeat superior.

Unlike traditional licensure statutes, it was felt that this proposal should not specify a permissible scope of practice for the assistant. Rather, it would be for the individual physician to determine what his assistant can or cannot do, upon consideration of his needs and the particular qualifications of his assistant. This flexibility was felt desirable in view of the variations both in types of practice and capabilities of assistants.

From the standpoint of the public, such a statute, by removing the fear of unwarranted civil and criminal liability, is likely to encourage the development and effective use of new types of personnel so badly needed in view of the existing and forecast physician shortage. Public protection should be assured by the physician's

liability in instances of actual negligence and his knowledge that if he does not in fact exercise direction and supervision he will not benefit from the exception's protection at all. Feeling was expressed at that conference, however, that regulation of assistants should not be vested solely in the hands of the individual physician but that the organized profession should exercise some control. It was decided, therefore, that the protection of the statute should extend only to cases in which the basic qualifications of an assistant to function in this relationship with a physician have been reviewed and approved by the Board of Medical Examiners.

Following the October conference, a draft of the suggested legislative proposal was prepared and circulated for comment and criticism among the conference participants and other interested parties. On the basis of responses to the first draft, a second draft was prepared, incorporating several suggested changes and clarifications. This too was circulated, and responses to it were solicited. It was felt that at this point, however, another meeting should be held for further discussion of the issues, in terms both of the draft of the October proposal and questions which had arisen with respect to it, and of new ideas regarding approaches to the problem. The meeting on March 1 was convened for this purpose. The group still appeared to favor the basic approach of an exception to the Medical Practice Act, and discussion focussed on the original proposal suggested in October and a variation of that proposal suggested and developed by one of the legal consultants on the project, Clark C. Havighurst. A brief statement regarding the two proposals is perhaps in order, to permit a comparison.

The October Proposal

§90-18 of the North Carolina Statutes, after prescribing the penalty for the unlicensed practice of medicine, reads:

> Any person shall be regarded as practicing medicine or surgery within the meaning of this article who shall diagnose or attempt to diagnose, treat or attempt to treat, operate or attempt to operate on, or prescribe for or administer to, or profess to treat any human ailment, physical or mental, or any physical injury to or deformity of another person: Provided, that the following cases shall not come within the definition above recited.

The proposal would be exception (14) to this definition of the practice of medicine. The second draft of the proposal based on suggestions made at the October conference reads as follows:

> (14) Any act, task or function performed at the direction and under the supervision of a licensed physician by a person approved by the Board of Medical Examiners as one qualified to function as a physician's assistant when the said act, task or function is performed in accordance with rules and regulations promulgated by the Board.

This proposal would establish a two-stage method of control. Organized medicine would participate in the regulation process in three principal ways, through the Board of Medical Examiners. First, before a physician or his assistant could have the benefit of the protection afforded by the statute, the assistant must have gained the approval of the Board of Medical Examiners, signifying that he has in some way demonstrated his qualification to perform under a physician's supervision. Determining precisely what criteria will govern the granting or denial of this approval will be the responsibility of the Board. It is anticipated that the Board might evaluate the curriculum, faculty, and facilities of the various programs and approve graduates of ones that it finds acceptable. (It is hoped that an accreditation mechanism will soon be developed for this type of program which could relieve the Board of the

program-evaluation task.) Having a presumption in favor of graduates of acceptable programs would reduce the burden of having to consider closely the qualifications of each individual applicant and would give assurance to persons entering approved programs that they will be able to function legitimately upon graduation. The consensus of the group was that the Board should also consider, presumably on an ad hoc basis, the qualifications and abilities of persons who have not had the benefit of a formal program but who have received appropriate training in some other manner. This would insure that academic credentials not be the sole criterion for approval to perform in this capacity.

Second, it was recognized that an assistant, once approved, may subsequently demonstrate incompetence or unwillingness to perform within the confines of the physician's direction and supervision. Similarly, it may later appear that the responsible physician is using his assistant in an inappropriate manner, with the assistant consenting by remaining in the situation. It was felt, therefore, that implicit in the Board's power of approval should be the power to deny or revoke approval under circumstances and in a manner prescribed by rules and regulations promulgated by the Board.

Third, the final clause would require the Board to consider what safeguards should surround an assistant's performance and to promulgate rules accordingly. An example of a rule which might be adopted under this clause is one requiring that the patient be adequately apprised of the assistant's status, as by an identifying name tag. This provision would also allow the Board to cope with other questions which might arise with the operation of the statute. For example, the degree and nature of direction and supervision

required of the physician is not specified in the statute. In recognition of the variety of tasks which could be delegated and the diverse capabilities of the individual assistants, it was felt that specificity would be unwise. The intent of the proposal is that the required degree and nature of direction and supervision should be that appropriate to the particular situation and circumstances. While immediate oversight by the physician may be necessary when complex procedures are to be performed, general instructions and subsequent review by the physician may be sufficient for routine duties. Further definition of these terms-- either to broaden or to restrict their meaning-- would render the proposed statute inappropriate for a variety of situations, and it is felt that physicians themselves must give the terms meaning in relation to particular circumstances. As long as there is no further definition, questions-- should they arise-- may have to be resolved in court, quite likely on the basis of expert testimony as to what type of supervision was appropriate to the circumstances. It may become apparent after experience with assistants, however, that some guidelines can be drawn with respect to certain typical situations. Such guidelines could be embodied in rules and regulations promulgated under this final clause.

The second stage of regulation would be in the hands of the individual physician, who would have two primary functions. First, it would be his responsibility to evaluate the particular skills of his assistant and to determine what tasks are and are not within his competence. Second, he must direct and supervise the activities of his assistant in order to bring such activities within this exception. As was stated previously, he should have adequate in-

centive to exercise caution and proper control since he will be vicariously liable for the negligent acts of his assistant and possibly directly liable if he knew or should have known that the assistant was not competent to perform the task delegated. In addition, activities not properly supervised may constitute the unlicensed practice of medicine, with the attendant dangers of criminal prosecution.

The Havighurst Proposal

The proposal advanced by Mr. Havighurst is also for an exception to the Medical Practice Act and reads as follows:

> (14) Any act, task, or function performed at the direction and under the supervision of a licensed physician by a person qualified by formal or informal training and experience to perform such act, task, or function when the said act, task, or function is performed in accordance with such rules and regulations as may be promulgated by the Board of Medical Examiners.

Obviously, this proposal has much in common with the proposal which arose from the October conference. It employs the above-discussed regulation by the physician, in terms of vesting in him the responsibility for evaluating the competence of the person to perform a particular task and for directing and supervising the performance of tasks judged to be within such competence. It also would charge the Board of Medical Examiners with providing safeguards in the form of rules and regulations to surround physician-delegated activity. It differs in two principal respects, the implications of which will be discussed below as the two approaches are compared. First, it does not give the Board the power and responsibility of initially approving the qualifications of the individual assistants. Primary reliance for the public's protection is placed on (1) the physician's ethical and professional judgment, (2) the deterrent effect of the malpractice risk attending use of

unqualified personnel, and (3) supervision by physicians' and hospitals' malpractice insurers. Mr. Havighurst also proposed that, should these be regarded as inadequate safeguards, the Board of Medical Examiners might be charged with investigating complaints concerning delegation to incompetents. He suggested that the Board be empowered to issue administrative cease and desist orders when, after notice and a hearing in which the burden of proof was on the delegating physician, it found that a particular assistant has been assigned functions beyond his competence. Under such a system, investigation could be initiated by the Board on its own motion or by complaints submitted by others to whose attention abuses have come, presumably physicians or aggrieved patients. He emphasized that protection against harassment by irresponsible patients or competing physicians might be provided by requiring sworn affidavits alleging grounds for the belief that abuses have occurred and by giving the Board discretion to refuse to initiate a proceeding if the complaint appears to be unfounded. He also postulated that the physician might be given the right to have an employee's competence certified in such a proceeding on his own motion.

Second, he eliminates the term "physician's assistant" from the statute altogether, for reasons which will be set forth below.

Comparison of Aspects

Public Protection. The primary consideration involved in developing any proposal, of course, is that the safety of the public be adequately provided for, and the proposals above evidence different evaluations as to how this can best be accomplished. Under both proposals it would be for the physician to determine what specific tasks the assistant can and will perform. The Havighurst

proposal explicitly states that the person must be competent to perform the particular task, but of course this is implicit in the October proposal. If the physician delegates and the assistant performs a task which the delegatee is not qualified to perform, both would likely be deemed negligent, and such actual negligence would certainly not be protected. It should be remembered that either proposal if enacted would be an exception from the prohibition against the unlicensed practice of medicine and would be useful in a civil suit only to prevent the drawing of an inference of negligence from the mere delegation to unlicensed personnel. Actual competence and negligence issues would have to be determined on the facts of the particular case. Mr. Havighurst argues that under the October proposal the incentives of the individual physician and his malpractice insurer for carefully monitoring the competence of the assistant will be weakened because they will relax in reliance on the initial approval given by the Board. As he points out, this argument is based on personal judgment and there is certainly room for disagreement, since Board approval would offer no protection when actual negligence (which may consist of delegating at all) is involved.

Mr. Havighurst postulates that professional liability insurance carriers may be relied upon to exercise some degree of supervision in situations involving physician use of unlicensed personnel for the simple reason that they have a significant financial stake in the competence of the auxiliary personnel. Some participants disagreed with this, however, largely on the basis of the additional energy and expense which would be required from insurers engaging in such a policing function. It was pointed out that insurance companies are currently not enthusiastic about their professional coverage and that putting them in the position of being expected to

assume additional supervisory functions might be sufficient inducement for them to pull out of this area of coverage altogether. It was also pointed out that because of the nature of their financial stake, insurers are inherently conservative and may exert a negative influence on the development and use of badly needed new personnel.

Under the October proposal, protection in addition to that afforded by the direction, supervision, and ultimate responsibility of the individual physician would be provided by the Board of Medical Examiners through a system of approval and disapproval of those who intend to function as assistants to physicians. Criteria upon which approval will be granted or withheld would be determined by the Board on the basis of its particular expertise and would be embodied in its rules and regulations. Fear was expressed by some that considering the financial and staff limitations of the Board, it may be unrealistic to think the Board can effect much regulation. Others, however, felt it preferable to increase the resources of the Board if necessary than to abandon this aspect of the proposal. It was pointed out that in view of the variety of functions assistants are and will be performing and concommitant differences in the types of training necessary, it may be difficult for the Board to grant or deny approval except in the context of the particular tasks to be performed, which may themselves change over time as new skills are acquired. The October proposal as presently constituted does not provide for submission of a job description by the responsible physician. There was some discussion as to whether Nathan Hershey's proposal, presented at the October conference, should be given further consideration. Basically, under that proposal the physician wishing to use an assistant would submit to his licensing board

(in North Carolina, the Board of Medical Examiners) a job description setting forth the tasks he intends to permit his assistant to perform. If the board felt the job were one within the capability of someone other than a fully-trained physician, it would give its approval and would specify qualifications deemed necessary for a person filling such a position. The physician would then find a person satisfying the qualifications and submit his name and credentials to the Board. Concern was expressed in October that requiring each individual position to be approved would create a mammouth job for the Board and would therefore entail significant delays between submission of the job description and approval. The group in October felt it to be politically unfeasible at the present time, in the sense that it could not gain the support of the medical profession, and apparently this sentiment continued to prevail at the March 1 meeting. Under the October proposal, therefore, the Board would approve candidates on the basis of fundamental qualifications it deems necessary for those performing in a physician-dependent role.

Under the Havighurst proposal there could also be provision for participation by the Board of Medical Examiners in the regulation of such personnel beyond the enactment of safeguarding rules and regulations. Rather than having the Board attempt to determine the competence of assistants ab initio, he would charge the Board with investigating complaints concerning delegation to incompetent personnel. He suggests that the Board be empowered to issue cease and desist orders in situations discussed above. This would ensure that if the physician were in fact abusing the privilege of delegation, organized medicine would not be powerless to stop the activity. Un-

like traditional license revokation, this would not necessarily deprive the physician or his assistant of a livelihood while the facts are determined because they could continue to function in areas in which competence has not been challenged. It was pointed out that health departments are at present generally authorized to issue such administrative injunctions in situations where delay may result in harm to the public. The specific example given was the power of public health agencies in many states to close restaruants and food storage places in instances in which there is danger that food has become tainted.

Categorization. Mr. Havighurst and Dr. Forgotson emphasized their feeling that the use of the term "physician's assistant", even though not capitilized, creates in fact a new category of health personnel. By creating such a new category, they argue, a unitary concept would be developed, embodying a fixed group of skills, presumably roughly equivalent to those possessed by graduates of the Duke and Bowman Gray programs. If this occurred there would be a severe restriction of manpower, since approval would not practically be available to those who had not had the benefit of a formal program. Mr. Havighurst for this reason eliminated the term "physician's assistant" from his draft and focussed exclusively instead on the delegatee's competence to perform a particular function.

The group assembled at the March 1 meeting agreed that the October proposal did present a potential danger in this respect, since the term "physician's assistant", though basically descriptive, has been associated with formal programs and their graduates. It was emphasized by Dr. Estes that this proposal is not intended to be addressed to a particular category but rather relates to a variety

of assistants, from the registered nurse to the informally trained person from the community, who are performing under a physician's direction and supervision tasks which have traditionally been performed only by the physician himself. It was apparently the sentiment of the group that the term "physician's assistant" in the October proposal should be changed to "assistant to the physician", which is descriptive of the relationship without carrying the strong connotations of being identified exclusively with program graduates.

Situation for Present Personnel. There was some disagreement as to the effect the October proposal would have on unlicensed personnel who are now being delegated tasks by physicians but who do not apply for or are unable to get Board approval. It was the contention of some participants that the existence of a mechanism whereby approval could be granted would give rise to an inference against many persons performing valuable services in the physician's office who for some reason are not approved. Mr. Havighurst cites this possible danger to unapproved personnel as a major reason for the elimination of the Board-approval aspect from his proposal.

Others felt that no practical danger would be presented in this respect. As far as civil suits are concerned, North Carolina courts have not to date allowed an inference to be drawn against a person performing acts within the scope of practice of a licensed profession merely because that person was not licensed. The approval system advanced in the October proposal would appear to give less basis for the drawing of an inference against those not covered than would the more formal licensing schemes. As far as criminal prosecution is concerned, it was pointed out that this would be an exception to the Medical Practice Act and would only be addressed

to those assistants arguably practicing medicine to some degree. The only "acts, tasks or functions" which need to be excepted at all are those which fall within the definition of medical practice. If someone other than a licensed physician or a person falling under another exception performs these acts at the present time, he is probably performing illegally unless he is protected by established custom and usage. There was an apparent difference of opinion as to whether present custom and usage protections for various personnel would survive the enactment of a proposal establishing an approval system. Dr. Estes suggested that perhaps the intent that such a statute not affect persons already protected by custom and usage might be expressed in rules and regulations promulgated under the statute.

Additional Discussion

Attention was also directed to the question of whether a hospital or other patient care facility could be the technical employer of persons otherwise eligible for protection under proposals of this type. It was felt by the group that they could be and that the key factor would be direction and supervision, which must come from a licensed physician in order for protection to exist.

Further discussion was given to the issue of whether it would be possible to formulate a list of tasks to constitute a formal "scope of practice" for physician's assistants that would be a meaningful limitation and yet would not be unduly restrictive. The point was made that no single task performed by a physician is so difficult that it could not with practice be learned and performed by a non-physician. The important distinction is the judgement exercised by the physician in choosing what tasks should be per-

formed in a given case. The group apparently felt that a formal scope of practice should not be defined and that the individual responsible physician should determine what would or would not be done by his assistant.

It was pointed out that consideration should be given to changing the term "licensed physician" to "physician licensed by the Board of Medical Examiners", since the general term "licensed physician" has been interpreted to include chiropractors. There was no objection to this change.

The final issue discussed concerned whether the October proposal would constitute an unconstitutional delegation of legislative power because clear standards for approval would not be specified in the statute. Although the issue of "adequate standards" has seemingly lost its importance at the national level, it continues to play a role in many states. It was felt that at this stage in the development of the concept of physician's assistants it would be unwise, if not impossible, to formulate specific standards to be embodied in legislation. It was felt that the Board of Medical Examiners are the best judges of the standards against which such personnel should be measured and could be more immediately responsive to changing needs and developments with regard to physician-dependent personnel. They would also have the benefit of developing custom and usage over time in determining their standards and exercising their discretion. It is perhaps noteworthy at this point that no penalties are intended to attach to non-approval of an assistant by the Board. The proposed statute is intended only to provide an added protection which does not exist at present. This may somewhat alleviate the need for the more precise standards often

required. It was suggested that although the "adequate standards" doctrine may present a problem, we should try to avoid specificity at this point. It was felt that if a good set of possible regulations were available at the time the proposal is introduced, the Legislature might be more inclined to make this delegation. It was recognized that at a later time the statute might be challenged, and a court might declare it void for lack of sufficient standards. If this occurs, the statute can then be rewritten, and hopefully the intervening experience with assistants to the physicians will make specification of more definite standards possible.

Conclusion

No attempt was made to formally poll participants as to the approach they favored. The general sentiment seemed to be that the October proposal might be more feasible from a political standpoint in North Carolina at the present time. It was decided that work should proceed on the development of a proposal and possible rules and regulations on the basis of the afternoon's discussion. It was emphasized that the ultimate success of any proposal would depend on its acceptance by the medical profession, particularly as represented by the Medical Society, and that future attention should be concentrated on providing full information to this group.

Meeting on Legislative Proposal
for Physician's Assistants
2:00 p.m. March 1, 1970

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| Dr. E. Harvey Estes, Jr. | Chairman, Dept. of Community Health Sciences<br>Duke Medical Center |
| Mrs. Martha D. Ballenger | Legislation Project Coordinator<br>Physician's Assistant Program<br>Duke Medical Center |

Legal Consultants

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| John H. Anderson, Esq. | Counsel, Medical Society of the State of North Carolina and North Carolina Board of Medical Examiners<br>P. O. Box 750<br>Raleigh, North Carolina |
| Dr. Edward Forgotson | Systems Service Department<br>Rand Corporation<br>1700 Main Street<br>Santa Monica, California |
| W. C. Harris, Esq. | Counsel, North Carolina Board of Nursing<br>P. O. Box 2454<br>Raleigh, North Carolina |
| Prof. Clark C. Havighurst | Duke Law School<br>(on semester leave to:<br>Northwestern Law School<br>357 East Chicago Avenue<br>Chicago, Illinois 60611) |
| Prof. Nathan Hershey | Research Professor of Health Law<br>Graduate School of Public Health<br>University of Pittsburgh<br>Pittsburgh, Pennsylvania |
| William C. Lassiter, Esq. | Counsel, North Carolina Nurses Association<br>P. O. Box 2298<br>Raleigh, North Carolina |
| David G. Warren, Esq. | Institute of Government<br>University of North Carolina<br>Chapel Hill, North Carolina |

Participants

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| Mr. James T. Barnes | Executive Vice-President<br>Medical Society of the State of North Carolina<br>203 Capital Club Building<br>Raleigh, North Carolina |
| Dr. Edgar T. Beddingfield, Jr. | President<br>Medical Society of the State of North Carolina<br>Wilson Clinic<br>Wilson, North Carolina |
| Mr. John Braun | Medical Rotation Coordinator<br>Physician's Assistant Program<br>Duke Medical Center |
| Dr. Joseph J. Combs | Secretary<br>North Carolina Board of Medical Examiners<br>717 Professional Building<br>Raleigh, North Carolina |
| Dr. J. Elliott Dixon | 215 East Second Street<br>Ayden, North Carolina |
| Dr. Frank Edmondson | North Carolina Board of Medical Examiners<br>167 McArthur Street<br>Asheboro, North Carolina |
| Mr. Carl Fasser | Assistant, Program Development<br>Physician's Assistant Program<br>Duke Medical Center |
| Mr. Marion Foster | Executive Director<br>North Carolina Hospital Association<br>Raleigh, North Carolina |
| Mr. Stephen L. Joyner | Physician's Assistant<br>215 East Second Street<br>Ayden, North Carolina |
| Mr. David Lewis | Director of Education<br>Physician's Assistant Program<br>Duke Medical Center |
| Mr. James C. Mau | Administrative Director<br>Physician's Assistant Program<br>Duke Medical Center |
| Rep. Kenneth Royall, Jr. | Representative, North Carolina General Assembly<br>64 Beverly Drive<br>Durham, North Carolina |

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