THE UTILIZATION OF PHYSICIAN'S ASSISTANTS IN GEOGRAPHICALLY REMOTE AREAS

John R. Ball, M.D., J.D.*

There is little question that there exists a maldistribution problem in health care in America today. The problem, however, is not so much that health manpower is maldistributed, but that health care services are maldistributed: that to a large number of people, services necessary to maintain or promote health are unavailable or inaccessible. Certainly, a major cause of the unavailability of health care services is the maldistribution of the providers of these services, largely physicians and hospitals. One method of attempting to alleviate the unavailability problem, then, is to bring the providers and the consumers closer together, and one way to bring them together is to do so geographically. This might be accomplished by bringing the consumers to the providers, a method which predominates today, or by bringing the providers to the consumers, a method for which a number of proposals exist. The former method is becoming increasingly unsatisfactory, as the distances between consumers and providers--culturally and economically as well as geographically--continue to increase. The latter method, largely untried, has already encountered a number of obstacles.

Emphasis on maldistribution of health manpower, which often means simply maldistribution of physician manpower, may well be misplaced, however. Proposals which have as their goal the redistribution or more even distribution of health manpower emphasize the providers of health services rather

---

*Research Associate, Department of Community Health Sciences and Assistant Director for Legal Affairs, Physician's Associate Program, Duke University Medical Center, Durham, N.C. 27710. Presented at the AMA Symposium on Distribution of Health Manpower, San Francisco, June 17, 1972.

than the consumers of those services or the services themselves. If the major maldistribution problem is that of health care services, then redistribution of the providers is successful only if that redistribution makes health care services more available or more readily accessible to the consumers. If services become the focus of discussion, it may be that redistribution of providers is only one possible solution. More importantly, once the emphasis is on services, it may be that there are a number of different kinds of providers of those services--a number of different people who may provide the same service. There is, for example, probably no single task within the practice of medicine which has not at some time been performed successfully by someone other than a physician. This is not to say at this point whether such a state of affairs is advisable or inadvisable, but it does serve to emphasize that the real issue in maldistribution is services, not providers. Viewed in this light, it may not matter who the provider of certain services is, so long as there are sufficient controls to assure the safety of the consumer-patient, acceptable to both the consumer and the provider. This presentation will discuss the part one category of provider--the physician's assistant--can play in the delivery of health care services and the sort of controls on his activity necessary to assure both continued quality of care and patient safety.

The concept of the physician's assistant is, of course, not new. Ancillary personnel have been used in health care for centuries and are now constant features in hospitals and physician's offices. Utilization is thus not an issue; patterns of utilization, however, continue to be the subject of discussion. Particularly important is the utilization of non-physician personnel in roles which once were the sole province of the physician. This development, relatively recent, has come about because of several factors

occurring nearly simulataneously. These factors are changing patterns of physician practice and demand for physician services, non-uniform distribution of physicians, and increasing stresses upon the primary care physician.

Physician practice patterns have changed as new areas of medical knowledge have matured into specialties, each demanding its share of the manpower pool while replacing high volume generalists with low volume specialists. Consumer demand for physician services has experienced an absolute increase, as better informed patients seek medical care for conditions which would have been handled without medical aid twenty-five years ago. There are striking variations in physician density between and within areas, variations which are likely to persist as long as the physician has free choice of practice location. Finally, these pressures are felt increasingly by the primary care physician who must carry a growing patient load, giving him less time for family, maintenance of quality care, or continuing education.

Utilization of assistants is one method by which needed health services may be delivered. It is not the only way demand for services could be met. The production of more physicians has often been urged as a partial solution to the problems of maldistribution and unavailability of services. But there is a growing belief that many of the tasks the physician performs do not require his specialized knowledge and long training, that health care is a complex combination of manual skills, data collection, and evaluation, some of which may be performed by others not so highly trained. There are, and must be, several different ways of acquiring such knowledge and skill, one of which is the direct path, independent of a previous category of provider--the physician's assistant.

In 1970, the Ad Hoc Panel on New Members of the Physician's Health Team of the National Academy of Sciences, in a succinct document, reported on physician's assistants. That report is an excellent beginning point

from which to discuss the categories of assistants now being trained and utilized. There are three basic types of physician's assistants, distinguished primarily by the nature of the services each is best equipped to render. Since each type has its own characteristic utility and in view of the great variety of functions among the types, it is not wise to rank them in any hierarchical order. Neither is it true that mere possession of an academic degree necessarily indicates the presence of all or many of the characteristics necessary in a good assistant. Thus, what is emphasized is not personnel, but the services delivered.

The assistant designated Type A functions much like the intern in a teaching hospital. He collects historical and physical data, organizes these data, and presents them to the physician who then determines the appropriate diagnostic and treatment steps. He coordinates functions of other more technical assistants, and may assist in diagnostic and treatment procedures. Like all assistants, he functions under the general supervision and control of a physician, although functioning in a variety of settings, he may perform under other than "over the shoulder" or "on the premises" supervision. He is distinguished from other types by integrative and judgmental abilities, general medical knowledge, and the ability to exercise a degree of independent judgment.

The Type B assistant is more limited in scope and function than the Type A assistant, but he possesses a greater degree of knowledge and skill in one clinical area or in certain procedures within that area. He might, for example, function only within a renal dialysis unit or within the specialty of ophthalmology. Since his skills and knowledge are more limited, he is thus less capable of independent activity.

The Type C assistant functions over a wide range of activities, but not possessing the level of knowledge necessary to exercise interpretive

and judgmental functions, he must perform under more direct physician supervision.

Training programs producing physician's assistants are increasing at a rapid rate, and now number almost as many as the number of total graduates to date. The AMA's Department of Health Manpower has reported that in July, 1971, there were 24 programs in existence, with a huge variation in quality, requirements, and goals. That same survey reported 184 graduates as of December 31, 1971. There are now more than 100 programs in various stages of development.

The Duke University Physician's Associate Program, in existence nearly seven years, produces a graduate most closely resumbling the Type A assistant mentioned above. In November of 1971, when the last such analysis was made, 67 of its 69 graduates were employed, one was in graduate school and one was deceased. Of those employed, 57 worked in clinical situation, 9 were in administrative positions, and one was in research. Thus, based on employment figures alone, it may be said that the physician's assistant is filling a need: he is aiding in the delivery of health services. Experience with the graduates thus far has shown in addition that they are well accepted by patients as well as physicians. One detailed study of the impact of a physician's assistant on the practice of a solo family practitioner revealed that while physician-patient contact time decreased, total health team-patient contact time increased. If physician time so saved had been fully utilized in seeing additional patients, there would have been an increase of 76% in patients seen. Usually, of course, the overworked physician will choose not to increase his patient load by the potential amount, but will prefer to use a portion of the saved time for recreational or educational purposes, both of which tend to increase the quality of his practice.

The physician's assistant, trained to carry out a variety of tasks and with the ability to exercise a degree of independent judgment, has the potential to increase not only the efficiency of the physician's practice in office and hospital, but also the delivery of care to those for whom health services have been inaccessible. There are two basic ways in which this might be accomplished: (1) by making physician practice more efficient, more patients might be seen, enabling the cost per patient to decrease and economic accessibility to increase; (2) by utilizing physician's assistants in areas distant from the supervising physician, thus making health services more geographically accessible. Although increasing economic accessibility to services tends to allow more people to receive those services, it probably does so to a lesser extent than increasing geographic accessbility. Since the maldistribution of health manpower is the subject to this symposium, geographic accessibility is then the more fitting subject for discussion.

The use of physician's assistants in areas geographically remote from physicians raises important issues both as to legal status and to medical care. Under the common law in absence of statute, it is generally said that physicians, who hold unlimited licensure, may delegate tasks to anyone they choose. There are certain controls on physician delegation, however: if the physician delegates to an unqualified person, or to one he should have known was not qualified, or if he delegates to one otherwise qualified and injury results through the delegatee's negligence, he may be found civilly liable. If the physician delegates a medical task to a person unrecognized by statute, he may be found criminally guilty of aiding the unlicensed practice of medicine. A final control on physician delegation is his own judgment: that he will neither undertake to perform nor delegate the performance of procedures he feels harmful to the patient.

In order to make more certain the probable common law right of delegation, and in order to control to a degree that delegation, 19 states had by the end of 1971 passed positive legislation relating to the activities of the physician's assistant. At least 5 others have passed such legislation thus far in 1972. Two basic types of regulatory systems exist. One is an exception to the medical practice act, recognizing the right of the physician to delegate certain tasks to qualified non-physicians and providing that such personnel shall not be deemed to be engaging in the unlicensed practice of medicine. The other type is specific, separate from the medical practice act, and provides in great detail for regulation. All specific legislative enactments contain provisions which would also except physician's assistants from the medical practice act. All states require PA's to function under the supervision, direction, or control of a licensed physician.

The use of paramedical personnel, like other social issues, may be subject to the test of balancing of the interests involved, i.e., whether the benefits received outweigh the costs incurred. The interests that must be protected by any regulatory scheme for health personnel are, it seems to me, basically three: (1) the public interest in improved health care, (2) the interests of the patient-consumer, and (3) the interests of the physician (and paramedic)-provider. A central issue in the use of paramedical personnel in geographically remote areas is that of supervision, and any standard of supervision will be workable only if it protects all three interests involved or if it produces benefits which outweigh its costs. Whether the standard will on balance do so will depend upon the content of "supervision" as defined by the law and by medicine.

There are three basic ways in which the scope of PA practice might be limited: physician supervision, statutory regulation, and administrative

regulation. All three are presently in use in this country. The two dozen states which have no positive legislation regulating the activities of assistants to physicians apparently depend solely upon physician supervision as the mechanism of control. Other states have limited in other ways the scope of PA practice. For example, the California statute provides that "[n]o medical services may be performed...in any of the following areas: [listing optometric and dental procedures]." The North Carolina Legislature has delegated the task of defining the scope of PA practice to the State Board of Medical Examiners. By administrative regulation, the Board requires that:

> [T]he 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.

Although the above mechanisms exist for limiting scope of practice by defining "supervision" more clearly, both the legislatures and the courts apparently have avoided doing so to any significant degree or with any consistency.

It is reported that three operating levels of supervision are being considered--over the shoulder, on the premises, and remote with monitoring. Florida, however, is apparently the only state that has attempted to define by statute "supervision" relating to paramedical personnel:

> "Supervision" means responsible supervision and control, with the licensed physician assuming legal liability for the services rendered by the physician's assistant. Except in cases of emergency, supervision shall require the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician's assistant. The board of medical examiners shall further establish rules and regulations as to what constitutes responsible supervision of the physician's assistant.

Alabama, in regulating optometric services, speaks of "the physician's direct personal, physical supervision." The word "present" used by several states does not lend itself to precise definition, interpretations varying from within reach to ability to see. It is reasonably clear that the words "under the direction and supervision of a licensed physician" used in most statutes do not require the physician to be looking over the shoulder of the assistant, nor do they require his presence in the same roon. What they do require is unclear. It will probably be that the interpretation placed upon the words by the courts will be "reasonable supervision." Other than that general statement, one must wait for judicial interpretation on a case by case basis to begin to define more specifically what "supervision" involves.

In the absence of comprehensive legislative or administrative prescription of supervisory requirements, the rule of reason adopted by the courts would take into account all the surrounding circumstances, including a balancing of the interests involved. For example, in addition to prior case law and the legislative enactments of other jurisdictions, reviewing courts would pay attention, as in many cases involving physicians, to the "custom and usage" of the profession, i.e., how physicians are presently utilizing assistants. The courts would also consider the societal need for flexibility in the use of paramedical personnel balanced against the necessity for some control of paramedical activity in the protection of the individual patient. In addition, the courts are not likely to define "supervision" regidly, given the wide variety of practice settings, types of practice, and kinds of tasks the assistant would perform. Different situations require differing degrees of supervision.

With particular regard to the use of the physician's assistant in areas geographically remote from his "supervising" physician, the issue is whether

courts--and--juries--will implement the reasonableness standard adequately to take into account the tradeoffs between supervision and service and of the economic factors which may dictate the circumstances under which medical care is rendered. Whether in an underdoctored area some attenuation of the supervision rule will be allowed so that more people can receive adequate care is unknown. Although the trend away from the "locality rule" is growing, courts should not be allowed to ignore completely limited local supply of medical care in a determination of reasonableness of supervision. The motives of the supervising physician may well be a factor in a balancing of the interests involved. Thus, there might be a tendency for the court to allow broader discretionary supervision when there is a bona fide attempt to provide needed care and to narrow that discretion where the motive appears to be profiteering.

A too rigid definition of supervision by the courts, legislatures, or boards of medical examiners would tend to dilute the effectiveness of the utilization of physician's assistants in the delivery of needed services. Certainly, the interests and safety of the individual patient must be protected. However, with the increasing sophistication of audiovisual communications, the technology of long range information transmission of all sorts, and the use of comprehensive standing orders, the goals of both quality and accessibility of services can be reached.