Physician's Assistant Program

Duke University

October, 1969

A Resume of Proceedings of the Conference
on Legal Status of Physician's Assistants

At 2:00 p.m. on October 26, 1969, a two-day conference on the legal status of physician's assistants was convened at the Hilton Inn in Durham, North Carolina, by Dr. E. Harvey Estes, Jr., Chairman of the Department of Community Health Sciences, Duke University. The conference represented the culmination of the initial phase of ayear-long study, sponsored by the Department of Health, Education and Welfare, to determine the most desirable and feasible means of accommodating emerging groups of paramedical personnel into the legal framework of medical practice. To a greater or lesser degree, all states regulate the practice of medicine and the activities of those who assist in rendering health care. To date this regulation has been achieved primarily through licensure, with physicians being granted an unrestricted license and nurses and other auxilliary personnel being granted limited licenses. The impetus for this study was the recognition that the very existence of these licensure schemes raises questions about the legal status of and control measures for new types of health care personnel who have not achieved such formal sanction of their activities. Although the immediate focus of concern is on the physician's assistant in North Carolina, the objective of the study is the development of a model legislative proposal which will be adaptable to other emerging health manpower categories and to other states.

At the outset of the conference, five alternative courses of action were presented for consideration: (1) maintaining the status quo (i.e., doing nothing); (2) licensing physician's assistants; (3) enacting a general statute authorizing supervised delegations by physicians; (4) specially licensing physicians to utilize physician's assistants; and (5) establishing a Committee on Health Manpower Innovations to control development and utilization of new personnel. During the

course of the proceedings several variations of the original proposals were presented, which will be discussed in conjunction with the respective proposals. The ultimate consensus of opinion was that effort should be directed initially toward the drafting of a general statute authorizing supervised delegations by physicians, with responsibility for determining which persons may accept such delegations vested in the State Board of Medical Examiners. It was contemplated that subsequent activity in this area should proceed in two additional phases, the first being that at a later date a committee responsible to the Board of Medical Examiners be organized and charged with defining the permissible scope of practice of a physician's assistant and developing means of certifying such personnel within the State. The final phase would be the establishment of an independent board responsible for coordinating and defining the scope of practice of all allied health personnel. It is not anticipated that the latter two phases will be fully developed as part of the current project.

The first alternative presented, that of maintaining the status quo and taking no formal action with respect to the physician's assistants, was unanimously rejected by the conference participants, primarily because of the danger of civil and criminal liability attendant to the current situation for both the physician and the physician's assistant. Although it was acknowledged that liability should continue to attach in instances of actual negligence, it was felt that the possibility of incurring a penalty for mere delegation to or performance of a task by personnel not formally recognized should be eliminated. Aside from recognition that the parties presently involved should be relieved of undue financial and professional risks inherent with the lack of legislative sanction, concern was expressed that the possibility of such additional liability may in practical fact preclude the physician's assistant from effectively utilizing his training and making the anticipated contribution to health care delivery.

Also unanimously rejected was the proposal that physician's assistants be licensed in a manner similar to other health manpower groups. Although licensure would resolve the liability problems, the participants felt that its tendency to fragment health care delivery, to freeze roles at what later become unrealistic levels, and to impede occupational mobility and entry into the field by imposing specific formal educational requirements made it an undesirable solution. The primary justification for licensure is the attendant assurance of the competence of practitioners, at least at the outset. It was felt that the problem of incompetence of physician's assistants is minimal since they do not function independently but rather under the supervision of a physician, whose vicarious liability for the assistant's negligence should be incentive for him, the physician, to monitor competence. An additional problem posed by the physician's assistant concept itself is the projected training of increased numbers of specialists within the general category. If licensure is pursued as the initial solution for the physician's assistants of today, the qualifications and scope of practice specified may not be adequate for the specialists of the future. This approach would, therefore, necessitate frequent resort to the legislature for modification of the original license or the enactment of additional ones.

The last three alternatives received greater considertion, and the course of action ultimately agreed upon has elements of all three. It was felt that the first step in the development of a legal framework should be the enactment of a general statutory exception to the State's Medical Practice Act, similar to that in Oklahoma, stating that the Medical Practice Act should not be construed to prohibit services rendered by a trained physician's assistant under the direction and supervision of a licensed physician. The enactment of such an exception would preclude liability based on the mere fact of delegation rather than on actual negligence.

Concern was expressed, however, that such a statute is too vague in that it does not specify the type of delegations which are permissible nor define the term "trained physician's assistant" for the purposes of determining exactly which persons may accept delegations. To remedy this, variations of alternative (4), special licensure of physicians, were considered. As originally conceived, under this approach the physician wishing to employ such an assistant would be specially examined with respect to his ability to supervise, the feasibility of using an assistant in his type of practice, and his professional integrity, to insure that he would in fact exercise proper supervision. He would then be granted a special license authorizing him to utilize an assistant. Although this type of formal additional licensure was rejected, it was felt that because the assistant is in reality extending the service potential of the physician, control should be exerted through the mechanism set up to regulate medical practice, namely the State Board of Medical Examiners. One means suggested for accomplishing this was requiring physicians to submit to the Board job descriptions for positions which need to be filled within their respective offices. The job descriptions would also specify the qualifications deemed necessary for a person filling such a position. The Board would then consider this description and if the job did not conceptually violate the Medical Practice Act they would give their approval. The physician would then find a person satisfying the qualifications and submit his name and credentials to the Board. (It should be noted that this approach could be used for other types of personnel functioning under different supervision in the health care setting. For example, nurses and hospitals could establish a similar framework for gaining the approval of their respective licensing boards for new types of personnel under their supervision.) Such a scheme could be effected merely be adding to the general statute discussed above a provision that the delegatee be performing pursuant to a job description approved by the Board of Medical Examiners. This approach has the

advantage of flexibility, in that it avoids the necessity of naming classifications of personnel and allows modification - either expansion or contraction - of roles as the need arises, without resort to the legislature. It also has the advantage of defining the scope of practice in terms of the particular situation and avoids the necessity of establishing a separate board to control the use of sub-physician personnel. Concern was expressed by those with legislative experience in North Carolina, however, that such a proposal would stand little chance of success in the legislature at the present time. It was felt that requiring each individual position to be approved would create a mammouth job for the Board of Medical Examiners and would therefore entail significant delays between submission of the description and its approval. It was predicted that such a proposal could not gain the support of the medical profession at this time, and a united front by the profession is virtually essential in securing this type of legislation.

Although the above job description approach was deemed unfeasible at the present time, it was felt that the basic idea of vesting control in the Board of Medical Examiners was good. It was decided, therefore, that in the initial phase there should be appended to the general statute authorizing delegations a requirement that the delegatee be approved by the Board as a person qualified to perform tasks under the physician's supervision. It is anticipated that in the early stages, the Board will consider the curricula of the various programs and approve graduates of acceptable ones. This would somewhat relieve the burden of closely considering each individual applicant and would give assurance to persons entering approved programs that they will be able to function legitimately upon graduation. In addition, the Board would be able to consider on an ad hoc basis those persons performing in the capacity of a physician's assistant who have not had the benefit of a formal program. These persons would of course be investigated more closely with respect to their qualifications and abilities, but such a scheme would insure that those without academic credentials would not be automatically excluded. There

was some concern that physicians might be lax in seeking approval of their employees, but it was pointed out that since such approval would be necessary to avoid the additional liability which could inhere merely for improper delegation, the insurance carriers for the practitioners might in practical fact perform an informal policing function.

Under the above initial phase of regulation there would be no specification as to the permissible scope of practice for the physician's assistant beyond the fact that he could not diagnose or prescribe treatment. Actual determination of his role would be left to the discretion of the individual physician employer, on the basis of the assistant's capabilities and the physician's needs. Questions may still arise, therefore, as to whether a particular delegation is proper, and recognition that an improper delegation would continue to be actionable should inject caution into the actual delegation practices of the individual physician.

Experience with this system may disclose a need for a more formal definition of scope of practice or more formal guidelines as to what constitute proper delegations. At that time it is proposed that a committee be organized under the State Board of Medical Examiners to develop such a definition. This would be essentially the second phase of a regulatory program. A determination was not made at the conference as to whether this would require additional legislation or whether it could be accomplished under the Board's general rule-making power. Because such definition has traditionally been an aspect of licensure, effected by the legislature, it is likely that specific delegation of this task by the legislature, along with general standards to govern the development of a definition, would be necessary.

Under the above scheme it appears that the problems of the physician's assistant per se could be resolved. It was recognized, however, that the basic issue is broader than the question of how to fit this particular emerging category into the health care framework. Because of expanding knowledge, the popu-

lation increase, and the reorientation from "medical care" for those who can afford services to "health care" for society as a whole, it may be forecast that in the coming years many new types of paramedical personnel will be entering the picture. The sentiment in the country today seems to be against extending the licensure scheme to accomodate these new groups of personnel. It was suggested at the conference that the eventual resolution of the problem might lie in the establishment of an independent board or committee charged with regulating the practice of all allied health professionals. Such a body would be responsible for determining the qualifications and scope of practice for all auxilliary personnel and for generally coordinating the activities of the various groups. This type of board would provide the flexibility necessary for keeping the roles of the personnel groups more immediately responsive to their capabilities and the needs of health care delivery over time. Composed primarily of representatives of health professions, the board would have the expertise required for making such judgements. No agreement was reached as to whether the board should formally license members of the various groups, certify them or merely approve their general activities and maintain supervision. The creation of this board was regarded as the third step in the development of a regulatory program, and some participants felt that it would be established at the national level rather than by the individual states.

It was decided that the present project should be concerned primarily with developing the first stage of regulation, namely the general statute authorizing supervised delegations and the vesting of responsibility for determining proper delegatees in the State Board of Medical Examiners. It was acknowledged that in practical fact this limited legislation might prove adequate and that it may not be necessary to proceed further. It was suggested, however, that in the drafting of this initial legislation as much consideration as possible be given to questions which may arise pertaining to the development of further regulation, should that prove necessary, in the interest of coordination and avoiding unnecessary duplication

of effort.

Drafts of the initial legislation will be circulated among the conference participants and other interested parties for comment and criticism, and another conference will be held in the early part of next year to discuss and refine the final product of the drafting effort. It is hoped that following that conference, effort may be concentrated toward securing the support necessary for enactment of the legislation by the North Carolina General Assembly in 1971.

Conference on the Legal Status of Physician's Assistants

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(Committee Working Draft)

Essentials for an Acceptable Program for Training Physician's Assistants

These guidelines are prepared because of the recognized need for educational standards for programs training physician's assistants. In order to be of maximum value, such standards must be general enough to allow innovation, yet precise enough to insure a level of quality acceptable to educational institutions, physician employers, medical review boards, professional liability insurance carriers, and others. These guidelines have been prepared with these dual objectives in mind.

Within the framework of organized medicine, there are two organizations which have assumed primary roles in maintaining the quality of educational programs for physicians: the American Medical Association, and the Association of American Medical Colleges. It is logical that one or both of these organizations assume similar responsibility for educational programs for physician's assistants.

It is proposed that one (or preferably both) of these organizations forms a Board of Evaluation and Registration (hereafter referred to as the Board) for regulation of Physician's Assistant Programs, and registration of competently trained physician's assistants. Its membership should be appointed by the participating organizations, and it should consist of five or six members (five if one organization, six if two). The functions of the Board will include providing guidelines for institutions interested in initiating such programs, evaluation and accreditation of newly established programs to insure the maintenance of high educational standards.

Essential prerequisites for a program are: (1) that it be affiliated with a college or university that maintains a cooperative arrangement with one or more teaching hospitals, and (2) that its graduates fit the established pattern of physician's assistants by working in a dependent relationship under the direction and responsibility of qualified physicians.

Certain information about each program should be provided to the Board to be available in turn to other educational institutions, physicians, hospitals, prospective students, and others. This information should include the following:

Name and Location of School

Hospital Affiliation

College/University Affiliation

Physician in Charge

Student Capacity

Month Classes Begin

Tuition

Sufficient information should also be provided to insure the Board that the program is in compliance with the following guidelines, which are established to insure the quality of the educational programs, welfare of the student, and protection of the public and the medical profession.

I. Administration

1. Acceptable programs for training physician's assistants may be conducted by approved medical schools, hospitals, or other acceptable clinics organized in accordance with present educational standards and in conjunction with a university or college.
2. All training of physician's assistants shall be under competent medical control.
3. Resources for continued operation of the program should be insured through regular budgets, gifts, or endowments, but not entirely through students' fees.

II. Organization

4. Adequate space, light and modern equipment should be provided for all necessary teaching facilities. A library containing up-to-date references, texts, and scientific periodicals pertaining to clinical medicine, its underlying scientific

disciplines, and its specialties should be maintained or be readily accessible to the institution.

5. Satisfactory record systems should be provided to document all work carried on in the field of patient care. Monthly and annual business and professional summarizations of the hospital or clinic affiliate should be available.
6. Transcripts of high school and college credits and other credentials must be available for each student. To enable appropriate registration, it is essential that standards of entrance qualifications and evaluations be recorded with and acceptable to the Board. An acceptable school will keep records of each student's attendance and grades, and will also record the type of tests performed. In addition, the school must have a complete and detailed curriculum on file, a synopsis of which will be submitted to the Board and thereby be available to the Association of American Medical Colleges, and the American Medical Association. This curriculum should include a detailed breakdown of the scope and content of all didactic material and clinical exposure and participation. An outline of all instruction should be supplied.
7. At least four students should be enrolled in each class.

III. Faculty

8. The school should have a competent teaching staff. The director must be a graduate of medicine who is licensed to practice in the location of the school and who has had training and experience acceptable to the Board. He shall take part in and be responsible for the actual conduct of the program. He, or his representative, shall be in daily attendance for sufficient time to properly supervise the progress and teaching. He should have at his disposal the resources of competent personnel adequately trained in the administration and operation of educational programs.
9. The staff must include at least one instructor who is a graduate of medicine,

in addition to the medical director. The teaching faculty may consist of people other than physicians, but more than half of the total instruction must be provided by physicians.

IV. Prerequisites for Admission

10. Prerequisites for admission for physician's assistant students should be approved by the Board and comply with one of the following sets of criteria:

    A. Diploma Granting Programs:

        1. A high school diploma from an accredited high school or successful completion of an approved high school equivalency examination.
        2. A three year health related background comprised of education and/or experience in direct patient care.
        3. Three letters of recommendation including one from a physician with whom the applicant has recently worked.

    B. Degree Granting Programs:

        1. A high school diploma from an accredited high school or successful completion of an approved high school equivalency examination.
        2. The successful completion of the prerequisites for a Bachelor of Science or Bachelor of Arts degree from the affiliated college or university. These courses should include not less than three semester hours each in mathematics and physical sciences and not less than six semester hours in biological sciences. Certification of the proficiency of a student by a college in any of the above required subjects may be accepted in lieu of those requirements.

11. Only those students meeting one of the above sets of prerequisites may participate in the professional portion of the program. Schools are encouraged to participate in affiliated programs leading to an academic degree. Schools are also encouraged to structure their degree programs so that the completion of the professional programs and successful certification and registration of the student can be applicable

towards a degree so that an individual can be granted a degree upon completion of the other necessary prerequisites.

V. Didactic Curriculum

12. The course of professional training should include in-depth teaching of the following subjects: Anatomy, Physiology, Pharmacology, Nutrition and Metabolism, History Taking, Physical Examination, Basic Laboratory Procedures, and Clinical Medicine.

13. The instruction should follow a planned outline and include text assignments, lectures, discussions, demonstrations, supervised practice, and practical oral and written examinations to assure adequate student evaluation.

VI. Clinical Curriculum

14. Each student should receive practical instruction and clinical experience adequate in scope and depth and under competent supervision to provide an understanding of evaluative and therapeutic techniques and procedures of at least one defined area of clinical medicine. Participating hospitals should be accredited and should be otherwise acceptable to the Board. Approved schools should have the availability of hospital services of at least 200 beds and yearly admissions of at least 6,000 patients. Community based clinical experience and teaching should be included in the program.

VII. Ethics

15. Students will be required to conduct their performance in accordance with the ethical standards of the parent institution. Failure to comply with these ethical standards may be cause for their immediate removal. Registered physician's assistants will be required to conduct their performance in accordance with the ethical standards set by the Board. Failure to comply with these ethical standards will be cause for immediate removal from the registry.

16. Schools conducted primarily for the purpose of substituting students for paid professional help will be not considered for approval.

VIII. Health

17. Applicants will be required to submit evidence of good health and successful vaccination, and the report of a medical examination should be part of the student's record. This examination should include an x-ray examination of the chest. Provisions should be made for medical care and hospitalization when necessary for a reasonable length of time.

IX. Admission to the Approved List

18. Applications for approval of a school for the training of physician's assistants should be made to the Board. Forms will be supplied for this purpose on request and should be completed by the director of the program requesting the approval. Information regarding the registration of qualified physician's assistants should also be acquired from the Board. Individuals interested in registration of qualified physician's assistants should address their inquiries to the Secretary of the Board. Only those individuals who meet the requirements will be registered and designated by the title of Registered Physician's Assistants.
19. Approval of an institution may be withdrawn whenever in the opinion of the Board the school does not maintain an educational service in accordance with the above standards. Whenever a training program has not been in operation for a period of two consecutive years, approval will automatically be withdrawn.
20. Approved schools should notify the Board of changes in the curriculum or directorship of the program.

THE UTILIZATION OF PHYSICIAN'S ASSISTANTS IN HOSPITALS*

SUMMARY

In order to fulfill the desired role, a physician's assistant must be able to participate in every setting in which his physician employer functions. There is nothing to preclude the use of physician's assistants in the hospital setting as indicated by the status of the following three issues relating to such use of trained physician's assistants.

First, existing legislation in every state is compatible with utilizing physician's assistants in the hospital setting so long as the assistant is under the direct supervision of a physician and functions within the limiting legal framework.

Second, the current position of the Joint Commission on Hospital Accreditation is compatible with the use of physician's assistants in the hospital setting. So far as is known, no health related professional organization has taken any stand in opposition to this issue.

Third, in all existing situations the issue of professional liability coverage has created no difficulty for the hospital, the physician, or the physician's assistant.

A procedure has evolved for implementing the necessary steps for adequate legal and ethical support. This procedure involves both the physician and the hospital as follows:

1.) The physician who employs a physician's assistant and wishes to utilize him in the hospital setting should make a formal request to the hospital director for individual limited privileges for his assistant. This document should include: a.) information on the assistant's background, character, education, and training; b.) a detailed breakdown of the proposed functions of and desired privileges for the assistant; and c.) the proposed measures of control to be utilized and the limitations to be observed.

2.) The hospital director, upon receipt of this request should first check with the hospital legal counsel to determine what changes, if any, are necessary in the hospital charter and bylaws. The request would then be handled in accordance with the existing rules of operations.

3.) After approval by the necessary committees and individuals within the organization, appropriate notifications can be made.

*Details relating to these issues and procedures are covered in detail in the following transcription of the proceedings from a symposium held in Greenville, North Carolina on Friday, September 5, 1969 before the Board of Trustees of the Pitt County Memorial Hospital, the Executive Committee on the Medical Staff, representatives of the Bylaws Subcommittee, the hospital's legal counsel, and other interested people.

PROCEEDINGS

Introduction: by Dr. John Elliot Dixon

DR. DIXON: As you know, I have hired a physician's assistant to assist me in my practice of medicine in Ayden, North Carolina, This assistant, Mr. Stephen Joyner, has met many of the physicians on the staff of the hospital, many of the nurses working in the hospital, the administrators associated with the hospitals functions, and many of my patients. Mr. Joyner has been very well accepted by all these people.

The purpose of this symposium is to introduce Mr. Joyner to the board of Trustees, and to let the members of this board learn about his background and training which qualify him to be a physician's assistant certified by the Duke University Medical Center. The gentlemen on the program will outline the background and training that the physician's assistants receive during the course of their two-year program at Duke, the functions of the graduates in hospitals elsewhere, and how an assitant, such as Mr. Joyner, can be integrated into the functions of a hospital, such as our hospital here in Pitt County.

This is a new and different concept in the field of medical services and it is a privilege to have the opportunity to be one of the pioneers for the utilization of such an assistant for the delivery of health services. The purpose of this meeting is to provide an outline of the mechanism for the acceptance of a physician's assistant into the hospital-related functions of medical practice. It should be remembered that the training of the physician's assistant is aimed at developing a qualified professional person to assist the doctor in providing services to more patients and, at the same time, maintain the same high quality of medical practice.

For this presentation we are honored to have Dr. E. Harvey Estes, Jr., Chairman of the Department of Community Health Sciences At Duke University, Dr. D. Robert Howard, Director of the Physician's Assistant Program at Duke University, and Mr. Kenneth Holt, Assistant Director at Watts Hospital in Durham, North Carolina. Dr. Estes and Dr. Howard will summarize various aspects of the physician's assistant program and Mr. Holt will describe how Watts Hospital has integrated a graduate physician's assistant from this program into their institution to actively participate in the provision of medical services. At this time I would like to turn the proceedings of this meeting over to Dr. Estes.

DR. ESTES: Thank you, ladies and gentlemen. It is a pleasure for us to be here and tell you about our physician's assistant's program and how physician's assistants can participate actively and effectively in the delivery of health care services. The Duke University Physician Assistant's Program has now been underway since 1965. The program started under the auspices and direction of Dr. Eugene A. Stead, Jr., then Chairman of the Department of Medicine who realized the growing need for augmenting available physician's services. The realization of this need came when, in 1963, a post-graduate education program for physicians was developed at Duke University. Because of poor attendance,

Dr. Stead made it a point to go out and see the physicians that he knew were interested in the program, but who had not attended. Investigations revealed that the majority of those physicians simply did not have time to invest because of the extensive time requirements of their practices. At about the same time, it became evident that within the specialty units at Duke Hospital personnel shortages were present which had not previously exhibited themselves. Many of these areas had recruited registered nurses and supplemented their training to fill specific needs within their structure but, at this time, the shortage of nurses was such that there were too few nurses to even provide the necessary patient care services on the wards. This combination of facts led Dr. Stead to look for other means of solving this critical manpower shortage.

It was obvious from the begining that a new source of manpower had to be utilized. Dr. Stead observed that there were individuals with a military background working in the medical center and providing services of extremely high quality after limited specialized training. From this he conceived a program that would provide people with experience from a military medical background with formal training and further experience to enable them to function at an intermediate level in the delivery of health care services both in an out of the hospital setting. His idea was to train an individual that could supplement the services of other available health team participants and provide services for the physician in all the geographical areas in which he was involved.

A two-year program was developed to train such a person. In accordance with these objectives, a small class of three individuals was matriculated into the physician's assistant program. Because of the need to evaluate the skills and services these individuals could offer following completion of the program, they were recruited back into service at Duke Hospital. Of these three, one worked in a research setting and the other two worked in a setting primarily dedicated to patient care services. Because of the initial success of the program, subsequent classes have been increased in size to the point where we now have fifteen students in our first year group and will be accepting forty students to the next class that will begin later in September of this year. Currently the program has seventeen graduates, many of whom are working outside of the medical center in various clinical situations. Two of the graduates are with general pratitioners in eastern North Carolina, one is in Raleigh working in the North Carolina State Prison System. Two are in practice situations away from the medical center in Durham and one is in Vermont. Of the twelve students soon to graduate the majority will be accepting employment opportunities away from the medical center. The program to date has been successful beyond all expectations of those who watched its early beginning. First of all we have been successful in selecting a group of individuals who have been outstanding in all respects. This is due in no small part to the larger number of applicants we have had for each postition. From the beginning, however, we have chosen from a variety of backgrounds so that we could more accurately evaluate the application of a number of available manpower sources to this concept.

From the onset of this program we have been aware of the keen interest of both individuals and institutions across the country; there have been visits by representatives of other medical centers across the United States; and there have been a great number of articles written about the program in both professional and lay publications.

The gratifying interest evoked by the program is related to the realization that a well-trained physician's assistant can at least in part help overcome the cirtical physician shortage that faces this country today.

We feel that much of the success of our program has been because we rely on a source of already partially trained manpower. One of the programs in this country, which is a four-year program, takes people directly out of High School, but the remainder of the programs rely on a source of already partially-trained people. Specific requirements for our program require that each applicant have at least three years of experience in the health field, one of which was spent in direct patient care. The majority of the applicants and students are ex-military corpsman, though some have come from a civilian experience background. Because of these requirements the students are a good deal older and more mature than would be the case if we accepted the post-high school student as our manpower resource. In order to complete the requirements for application to the program, an applicant must complete an application form, obtain three recommendations, submit transcripts of his previous educational efforts and take portions of the College Entrance Examination Board exams. If the applicant meets our qualification standards he is invited to Duke for an interview with members of the Committee on Admissions. From the beginning, though we have taken into the program only those people we feel will be qualified to function as a physician's assistant, we have chosen people from various backgrounds and with varying degrees of experience and formal education so that various manpower resources could be more adequately evaluated.

Once selected for the program the student is enrolled in the 24 month course and upon completion is given a certificate by the university. Though, at this time, the graduate physician's assistant is not given a degree from the university, efforts are currently under way to provide the graduate with the opportunity of applying the eighty-two credits that he earns during the course towards a baccalaureate degree.

One question frequently raised regarding the utilization of the physician's assistant relates to the issue of his legal status. The need for an early legal directive was realized and on April 13, 1966 in response to an inquiry from an ad hoc Committee of the University, the attorney general's office ruled in reference to the medical and nursing practice acts that "nothing .... shall be construed in any way to prohibit or limit the performance by any person of such duties as specified mechanical acts in the care of patients ... when such care and activities are performed under the orders or directions of the licensed physician ..." It was recognized that, regardless of this interpretation, efforts should be made to modify the medical practice acts to allow the physician more leeway in the delegation of certain tasks. In accordance with this a conference relating to the legal status was held in Durham in the spring of 1968 from which guidelines were formulated for the development of new legislation. An attorney on our staff is now involved in working towards this objective. This project will entail a review of existing medical legislation, further conferences for the development of more formalized

guidelines, and the drafting of model legislation, which would ultimately be available to the state legislatures for adoption and implementation. To this time, however, there have been no legal problems and nothing seems to indicate any legal problems within the forseeable future.

One point regarding the utilization of the physician's assistant which should be emphasized regards his application in the hospital setting. In order to determine the position of the Joint Commission on Hospital Accreditation, we corresponded with Walter W. Carrol, M.D., the Associate Director of The Standards Revision Project for the Joint Commission on Accreditation of Hospitals. Because of interest in the physician's assistant concept, the commission was already in the process of revising the standards and had included a section on the utilization of allied health professionals. The revision was made so that approval of new types of health professionals could be approved for hospital staff functions. The provisional draft of the new standards reads as follows:

"The Medical staff should deliniate in their bylaws, rules and regulations the qualifications, status, clinical duties and responsibilities of members of the allied health professions. Individual privileges for limited practitioners and corresponding responsibility of the medical staff should be fairly stated to insure quality patient care." To amplify this a bit further, if physicians have in their employ allied health professionals for whom they desire limited hospital privileges, the medical staff has the right to amend its bylaws to define the privileges, responsibilities and control measures for these people. Then, within this framework, it is permissible for these individuals to function within the hospital setting. To quote from an already existing set of bylaws in another North Carolina hospital, under the section concerning allied health professions bylaws, a specific section for the physician's assistant is established. This section reads as follows:

"The physician's assistant shall conform to the rules and regulations as the medical staff with the following conditions. A. a qualified member of the medical staff must be responsible for the care of each patient seen by the physician's assistant. The physician's assistant is responsible to this medical staff member. B. The examinations and procedures performed by the physician's assistant must be those authorized by the responsible physician who assumes responsibility for validity of the observations and for the proper performance of the procedures. C. The physician's assistant will not write orders, except if specifically directed by the attending physician in which case the physician will sign the orders at his next visit. In such cases the physician's assistant will sign the orders with the physician's name per his own name."

There have been no legal cases involving graduates of our physician's assistant program either in this state or in any other state. Further, no cases have been decided on the utilization of physician's assistants in any court of record, although, there was one case in a Justice of the Peace Court in California. At this time their utilization relies primarily on the existing medical legislation but may well meet the criteria of usual and customary, or accepted practice, in a specific area. Some states have specifically ammended their medical and nursing practice acts to allow for legal incorporation of the physician's assistant into

the health care system. Oklahoma was the first to do this and they merely amended their medical practice act to allow the physician the right to delegate any of their tasks to trained physician's assistants. We are currently involved in a legal study at Duke University in which the objective is to evaluate current medical manpower legislation - primarily in North Carolina but also in other states - and to develop model legislation to be available for adoption by all states which will allow for the incorporation of new types of personnel into the medical and health care system.

One other question that frequently is raised regarding the physician's assistant is his relationship with the nurse. This is of particular interest in the hosptial setting. First, it can be said that the areas of responsibility are different for the nurse and for the physician's assistant as he must be responsible to a physician for his functions. On the other hand, the registered nurse is employed by an institution and is responsible to the institution itself. She participates in the care of all patients, no matter who the responsible physician may be. Another point of difference is that a physician's assistant is not fixed to a specific location or a specific period of time. He is geographically flexible and able to assist his physician in all the areas in which the physician himself serves. The same can be said for his temporal flexibility, in that he is not limited to any particular shift or any particular days of the week and works the same hours as his physician. Another area of difference is seen in their training in that the physician's assistant is not extensively trained in bedside nursing procedures. This is not the need they were designed to meet, nor is this an area in which they have any desire to principally participate. The difference in their training and in their function is very evident on the ward in that the physician's assistant participates primarily in the area of patient evaluation and in the accomplishement of technical procedures. We have found further that at the individual working level the physician's assistant and the nurse work extremely well together and by their complementary functions effect an improved level of patient care.

At this point I would like to turn the program over to Dr. Howard, who will explain to you the actual training the physician's assistant receives during his two-year course.

DR. HOWARD: As Dr. Estes indicated, there are differences in the training that the physician's assistant receives from that of the other allied professionals. The training program of twenty-four months is divided into a nine-month didactic portion and fifteen-month clinical portion. In the didactic portion the students are taught the basic medical sciences with an emphasis on the practical aspects. The first academic year, rather than being divided into two semesters, is divided into three phases,--an introductory phase of six weeks, a "core" phase of twenty-four weeks and a supplementary phase of six weeks. In the introductory phase the students take courses in the history, philosophy and ethics of medicine; basic clinical laboratory procedures; medical terminology; a review of inorganic chemistry; and an introduction to animal experimentation. In the "core" phase the emphasis is on teaching the majority of the basic sciences by a systemic approach. During this phase the students take courses in anatomy, physiology, essentials of chemical biology, clinical medicine, pharmacology, pathology, physical evaluation and bacteriology. In addition to these courses, the students are also given three courses each eight weeks in length that are

oriented to the clinic and laboratory. This group of course includes clinical chemistries, diagnostic procedures, and animal surgery. During the supplementary phase, students take courses in electrocardiography, introductory radiology, community health, basic principals of data processing and medical instrumentation. Also during this phase the students are given further training in patient evaluation with an extensive clinical exposure to aid them in the development of techniques in history-taking and physical examination.

The fifteen-month clinical training which immediately follows the didactic training is comprised of both required and elective rotations. All of the students are required to take a four-week rotation in health administration; a two-week library research rotation; and, in the last eight weeks of their training, a working rotation away from the medical center with community-based practitioners. Other required rotations, depending upon the specialty, include eight weeks on an inpatient service, eight weeks on an outpatient service, and four weeks with one of the clinics under the direction of the Department of Community Health Sciences. The remainder of the clinical training is spent on various elective speicalty service rotations.

Plans for the future of the program include expansion in both class size and the cinical scope of training available for the students. Initially, the program began with three students and developed in the area of general medicine. Since that time, the class size has been expanded to fifteen students in the class of 1970 and forty students in the class of 1971. Currently, physician's assistants are being trained in general medicine, internal medicine, general surgery and general pediatrics. For the class just beginning their didactic training, there will be nine additional areas for clinical training. These are for the most part specialized types of training programs and include neurosurgery, orthopedic surgery, urology, general psychiatry, maternal and infant care, radiology, industrial medicine, cardiology, and gastroenterology. It is proposed at this time that for 1972 we will matriculate sixty students and add ten more specialty programs, including opthalmology, otolaryngology, geriatrics, family planning, obstetrics and gynecology, dermatology, nephrology, allergy and respiratory diseases, endocrinology and neurology, Ultimately, plans include expansion to one hundred students per class with training available in virtually every medical and surgical sub-specialty. By including specialty-type training we can expand the class size and train assistants for all types of physicians by merely varying the clinical emphasis of the student's training.

One aspect of the Duke program that has allowed us to move forward as rapidly as we have with the development of this concept has been the extensive commitment we have made in evaluative measures. As the program has developed we have evaluated and monitored several aspects of the training program and the graduate's application to the health team concept. Initially, a role relations study was carried out for the purpose of determining the scope of the roles filled by the graduates in their practice setting. As a result of that study several more specific studies evolved. The first, a patients acceptance analysis, was recently completed and has been submitted for publication.

The second, an economic analysis of the physician's assistant, is currently underway. Part of the data for this second study is being accumulated in this area. Other studies that are currently underway include a health team utilization analysis, a physician's acceptance analysis, a study relating to the quality of patient care and a skill utilization study. These evaluations have, of course, been of great benefit to us, but their long run benefits will most likely be the aid that they can provide other institutions in developing their own training programs.

In summary, the physician's assistant is trained not as a new type of hosptial employee, but rather as an assistant for a physician. It should be emphasized that the physician's assistant is employed by a physician to work for a physician and to be responsible to a physician. The objective of the entire training program is to train an individual that can extend physician services and be sufficiently mobile to work in all of the settings in which the physician operates.

At this point I would like to present Mr. Kenneth Holt, who will elaborate on how one of the graduates was integrated into a hospital staff and the functions he serves in this setting.

MR. KENNETH HOLT: As Drs. Estes and Howard pointed out during their presentations the physician's assistant is trained to work directly under the auspices of a staff physician and it is in this relationship that the physician's assistant functions at Watts Hospital.

Watts Hospital's relationship with the Physician's Assistant Program dates back to 1966. At that time the first thing that we did was to consult with our legal counsel. The legal counsel requested that the supervising physician submit to the hospital documents stating the full qualifications of the assistant. He also requested that this document state exactly what functions the physician's assistant would be expected to do in the hospital setting, the procedures that he would carry out in the evaluation and care of patients, and a listing of all of the services he would perform. In addition to requesting that this document include what the physician's assistant would be doing, he asked the physician to clarify what the physician's assistant would <u>not</u> be doing. This was felt to be a necessary step so that neither the hospital, the assistant, nor the physician would be placed in a position of legal jeopardy. After receiving this information the hospital contacted its professional liability carrier and received approval for the utilization of the assistant in the hospital setting. The same course of action was taken by the physician for his own professional liability coverage and again there was agreement with the carrier that extended coverage to the assistant. After doing this groundwork, the attorney outlined exactly what procedures should be followed to grant the assistant his limited priviliges within the hospital setting. In compliance with this request the following steps were taken:

1.) A formal request by the physician to allow his assistant to participate in certain hospital functions under his direction was submitted.

2.) We requested from Duke University background information on the assistant as to his previous training, character, and qualifications, an outline of the training program

and confirmation of his certification as a graduate from their program. We also requested from Duke University a statement of the qualification of the assistant covering the defined scope of proposed utilization.

3.) Approval of the appropriate committees within the hospital structure and the hospital administration was then received.

4.) The final step was the letter of acceptance to the physician from the hospital granting the limited privileges as outlined in the document of request.

For your interest, the document that the physician submitted to the hospital involved patient care procedures, history-taking and physical examination, provision of inhalation therapy procedures within his scope of training, cardiac emergency procedures and cardiac monitoring, electrocardiography procedures, basic laboratory procedures and other miscellaneous diagnostic and therapeutic procedures which were outlined earlier as part of their professional training.

In preparation for this meeting it was suggested that I comment on the problems solved by utilizing the physician's assistant in the hospital setting and the problems created by utilizing this type of an assistant. To date there have been no problems of any consequences which we feel is due primarily to the fact that the assistant works directly under the supervision of the attending staff physician. At first there was some concern about the acceptance of the assistant by other professionals and paramedical personnel within the hospital including the nursing staff. Any fears that any people might have had, however, never materialized and the assistant has been fully accepted by all the people in the hospital with whom he works. He is so well accepted now, in fact, that the nursing staff would rather call him than the attending staff physician. He spends a great deal of time in the hospital with the patients and in doing so, lightens the load of the physician and aids the nurses immeasurably in their efforts to provide quality patient care. It has helped the hospital in that he has relieved some of the burden on the nursing staff. In providing his services he has never overstepped his bounds, or in any way tried to interfere with the nursing functions.

It might be some interest to this group that our attorney's independent investigation led him to the conclusion that utilization of a physician's assistant was within the confines of the law which we felt further substained the attorney general's interpretation of the law as mentioned earlier. The next legal investigation the attorney made was to determine whether or not there would be any conflict with the bylaws and regulations of the hospital. Careful review revealed that no problems existed. There was some question raised in reference to the taking of orders and the provision of patient treatment. In our institution we have followed the suggested guidelines and have allowed the assistant to take orders over the phone and sign the physician's name which the physician signs the next time he comes to the hospital. Regarding patient treatment, any treatment that fell within the confines of the original document that the attending physician felt the assistant capable of managing has been permitted. This has created no problem.

My personal belief from the administrative standpoint, is that we need increasing numbers of indiviudals of this sort in the hospital setting. As a paramedical person, he is not replacing existing services of people but is, rather, complementing our present staff. As I look to the future, the only real problem that I see is that of allowing the physician's assistant, as well as other allied health personnel, to develop to their fullest capacity and have within their grasp the ability to climb an academic and professional ladder. I would hope that these individuals would not have the desire to go on to medical school, but I think if they have both the desire and the capability, this opportunity should be open to them.

PROFESSIONAL LIABILITY INSURANCE
FOR THE UNIVERSITY TRAINED PHYSICIAN"S ASSISTANT

SUMMARY

The issue of professional liability insurance for the university trained physician's assistant has been considered by both the administration of the Duke University Physician's Assistant Program and most of the professional liability insurance carriers. In 1969 various aspects of this issue were placed before the major liability carriers, and the following represents an aggregate of current policy and standing:

1. Institutions sponsoring a physician's assistant type training program may have or can obtain coverage to protect its interests for the acts of students during their training program. This coverage can include the actions of the assistant while outside of the parent teaching institution so long as the student is engaged in activities directly related to his training.
2. Other hospitals beside the parent institution participating in such a training program may or can have similar coverage for qualified students operating within their confines.
3. Students are generally not covered by professional liability insurance, but review of the decisions by the higher courts reveals no case in which a student-defendent was held liable for negligent actions.
4. Although the probability of suit for professional liability concerning the acts of a student physician's assistant while in training away from the parent institution in minimal, protection of the physician supervisor is available. To date physicians who have desired to do so have received additional coverage for their own protection from all companies involved. The rate for this coverage has ranged from nothing to the same as that paid for other nonprofessional employees.
5. Graduates of a university-trained program who are employed by a physician can obtain professional liability insurance from most companies at a rate approximating fifty per cent of the rate paid by their physician employer.
6. Physicians employing graduate physician's assistants can obtain protection for negligent acts by their assistants at a very low rate.
7. Hospitals that utlilize the services of a physician's assistant operating as an employee of a physician may already have or can obtain protection against negligent acts of the assistant while on their premises.

To date policies established by all insurance carriers are tentative and subject to review pending further clarification that can only come with more extensive use of trained physician's assistants.

The recommended course of action to be taken by physicians employing physician's assistants is to: 1) have the issue of professional liability insurance clarified and established in all hospitals where the assistant

will function; 2) obtain necessary additional coverage for the utilization of the assistant in the practice of medicine as deemed necessary by the insuring organization, and 3) have the physician's assistant obtain professional liability insurance to protect his own interest for his professional endeavors.

It should be emphasized that to date there has been no case involving the negligence of a university trained physician's assistant, and, consequently, the policies of the carriers of professional liability will remain tentative in the forseeable future. Currently, adequate protection can be economically obtained from most major carriers. It should also be noted that the policies stated above and outlined in further detail below apply only to university-trained physician's assistants.

RESULTS OF CORRESPONDENCE ON PROFESSIONAL LIABILITY COVERAGE
FOR THE UNIVERSITY-TRAINED PHYSICIAN'S ASSISTANT

At the time of the initiation of the Physician's Assistant Program, the question of professional liability insurance coverage was first investigated. At that time investigation of this issue was limited to coverage of the students while in the Medical Center. They were then found to be automatically included under the existing policy carried by the Medical Center.

In 1966, when the first student was sent outside the Medical Center for community-based experience, the question of professional liability was again raised and the company that provided coverage for the physician involved agreed to extend coverage to the student at the same rate as the physician paid for his other employees.

From 1966 to 1969 all students and graduates of the Duke University Physician's Assistant Program, while away from the medical center, were associated in their training or employment with physicians who carried their professional liability insurance with this same company.

In 1969, as the expanded class was being assigned to physicians from coast to coast, the issue of professional liability was again raised. As a result of these inquiries and because this issue was relevant to all related programs, the issue was brought directly before each of the major professional liability carriers listed by the American Medical Association.

Of the fourteen companies currently listed by the American Medical Association, three companies (American Insurance Company, American Motorist Insurance Company, and Lumberton Mutual Casualty Company) failed to respond to the request for information, six companies (Insurance Company of North America, the Hartford Insurance Group, United States Fidelity and Guaranty Company, Aetna Insurance Company, and the Travelers Insurance and Indemnity Company and Security Insurance Group) referred the matter to the Insurance Rating Board of New York for decision, three companies (The Medical Protective Company, the Shelby Mutual Insurance Company, and the Saint Paul Insurance Group) took independent stands on the issue, one comapny (CNA Insurance) said they were not currently active in the area of medical professional liability insurance, and one company (Aetna Life and Casualty) deferred response until some further unspecified date. In short, fourteen carriers received correspondence, and of these nine carriers are both active in the medical professional liability area and chose to formulate an initial standing on the issue of professional liability coverage for certified physician's assistants. Of these nine companies five deferred to the policy of the Insurance Rating Board and four nonmembers formulated specific policies.

On September 18, 1969 the Committee on Professional Liability Insurance of the Insurance Rating Board met and formulated the following guidelines for their member companies:

1. The present Physicians, Surgeons, and Dentists Professional Liability policy is the appropriate vehicle for professional liability coverage

for the physician's assistant and that coverage under that policy will be entirely adequate.

2. The following statements would be added into the Physicians, Surgeons, and Dentists Professional Liability Manual:
   a. "Physician or Surgeons Assistants. This classification applies to physicians and surgeons assistants who have completed an approved course of study leading to university certification and who perform their duties under the direct supervision of a licensed physician or surgeon assisting in the clinical and/or research endeavors of the physician or surgeon."
   b. "Additional charges - Physician or Surgeon Employed Assistants. This classification applies to the physician or surgeon employing an assistant of the nature described [above]". In regard to the charge, the Insurance Rating Board said that a non-burdensome charge in accordance with the insurance market would be merited for the physician's or surgeon's assistant."
3. The above delineations represent two classifications - the first for assistants desiring coverage in their own name and the second for extension of coverage of the physician or surgeon to extend his own policy to include the university-trained and certified assistant.
4. Specific rate information was not delineated and though this will vary from area to area, it will probably be competitive with other companies.

In regard to the other responding companies the following guidelines have been established and are summarized in alphabetical order:

1. The Medical Protective Company
   a. A separate policy for the physician's assistant will not be written at this time.
   b. Policies covering physicians will automatically include the trained assistant if the assistant is joined as a co-defendent, and the assistant will be covered as a co-defendent within the limits of the policy.
   c. The coverage as described above will be provided at no additional premium except possibly in the area of radiology.
   d. This existing policy will be revised as required by adverse loss experience.
2. The Saint Paul Insurance Company
   a. Policies can be obtained for the university-trained physician's assistant both as an individual and as an employee of a physician.
   b. The rate will vary from state to state but in North Carolina it will be twenty dollars per year for five/fifteen thousand, and forty-one dollars per year for one hundred/three-hundred thousand for the individual policy for the assistant where assisting in surgery is not included in his duties, or fifty-five dollars and one hundred thirteen dollars per year respectively where the assistant's duties include assisting in surgery.

      In reference to the additional charge to the physician for coverage of himself for acts of the assistant and named as co-defendent, the rates will be five dollars per year for five/fifteen thousand and ten dollars per year for one hundred/three hundred thousand coverage. These figures are applicable only to the university

c. trained assistant employed by a physician in North Carolina
All coverage will be limited to liability for acts while the assistant is operating under the direction of a licensed physician.

3. The Shelby Mutual Insurance Company
   a. The student in training can be covered under provisions obtained by the parent institution.
   b. Professional liability can be obtained by the graduate of a university program at an approximate rate of one-half of the rate paid by the physician-employer.
   c. No specific rates regarding coverage of the physician-employer is quoted.

The preceeding information is a summary of correspondence to date with the major professional liability carriers and should be considered only as their current policies are liable to future alteration. These policies, so generously provided are meant by all companies to refer only to university-based and sponsored physician's assistant type of training programs.