Physician Extenders, the Law, and the Future

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The process of Physician Extender authorization through general delegatory and regulatory-authority model legislation in the various states is examined in this paper. In light of past legislative and professional developments, the likelihood of independent practice patterns emerging among both nurse practitioners and physician's assistants is assessed. It is concluded that current trends in physician manpower supply and distribution make the establishment of a physician extender group serving in competition with primary care physicians unlikely at this time. Rather, it is more likely that a clearly defined role may be established either in the employer/employee setting or through a position quite distinct from that of the primary care physician. Physician extenders functioning in this more independent role could contract with primary care and other physicians for their services without engendering economic competition for patient services.

Authorization—the General Delegatory Model

The concept of the Physician Extender or Physician's Assistant is not new. By 1900, the Russians had 32 schools producing Felchers, the functions of which were "to assist physicians (and) carry out their instructions," but "because of the shortage of physicians . . . many rural medical stations were headed by Felchers."[1] After their revolution, the Chinese instituted the related concept of the Barefoot Doctor.[2] Less well publicized, but perhaps more significant to the United States experience, are a host of other nonrevolutionary innovations with physician extenders throughout the developing world. A case in point is the Sudan, where medical assistants have been exercising a considerable degree of autonomy in delivery of primary health care for

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many years and are now being supplemented by still other community health personnel.[3] Though there may be variations in the model, experience throughout the world is similar. Physician extenders have been tried and utilized successfully in a number of settings where the physician supply has been limited.

Ten years ago the National Academy of Sciences dealt with the question of definition. That is, what is a physician extender? Focusing on physician's assistants, they defined three types—A, B, and C. The Type A assistant was defined as one capable of collecting historical and physical data, integrating and interpreting such data, and exercising some degree of independent judgment.[4] One definition of a Type A assistant includes the "ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment."[5] It is around this issue of independent judgment that many legal questions have arisen and alternative practice patterns have been suggested. Informal patterns of independent decision making have, of course, gone on for years and been a subject of some interest to behavioral scientists.[6]

If independent judgments are to be made by the physician extender, this may be either as an employee with clearly defined prerogatives or as an independent contractor. This distinction becomes exceedingly important in the law, as an institution or individual practitioner may be held personally responsible for the actions of an employee ("vicarious liability"), but may not be held responsible for actions of an independent contractor.[7] It is important to note that on this issue the two principal physician extender groups in the United States today have markedly different approaches. Nurse practitioners, representing the nursing profession, have consistently moved for more independence in decision making and role assignment. "Physician Assistants, on the other hand, make no claims to independence."[8] As will be noted at the conclusion of this paper, it is upon this issue that the future of these two physician extender groups will likely rest.

Recognizing that a physician is someone who professes to be the same, who diagnoses and treats disease, and who receives compensation for such services, it would be useful at this point to define the physician's assistant and nurse practitioner.[5] The physician's assistant has been defined as "a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."[9] Nurse practitioners, on the other hand, have been defined as licensed individuals "responsible for their own practice and accountable to their clients and their families for maintaining standards of practice."[10] The difference between these two classes of physician extenders, which could not be more clearly stated, focuses upon issues of independent judgment and accountability.

The issue for physicians should be equally clear. This centers around malpractice concerns if the physician extender is responsible to the physician, and around territorial infringement if the physician extender proposes an independent existence. A considerable amount has been written about the former, a relatively small amount about the latter. This probably relates to the fact that quality of care concerns and related ramifications are more amenable to professional discourse than are declarations pertaining to professional self-interest and protection.

The legal principle of "vicarious liability" or *respondeat superior*, simply stated, implies that the physician extender is the servant of the physician. The physician, as with any employee, has the right of control of this assistant. "The *right* of control exists and this defines this status as one of *master-servant*."[11] The concept of *respondeat superior* carries with it the consequence that "employers are liable for the negligent acts of employees performed within the scope of the employment relationship."[7]

The physician is not the only one at jeopardy in this relationship. Even in the clearly defined employer-employee setting, if the physician extender is, by definition, carrying out tasks typically reserved for the physician, the extender becomes vulnerable to legal sanctions imposed upon those who practice medicine without a license. As with physicians, physician extenders have thus found it necessary to protect themselves from malpractice claims through purchase of liability insurance (available either through the American Academy of Physician's Assistants or through the American Nursing Association) at relatively low cost.[12] Fortunately, malpractice experience with physician extenders has been limited and the at-

mosphere is favorable for continued availability of malpractice coverage at reasonable rates.

Much more fundamental for the protection of the physician extender than malpractice insurance is appropriate modification of the Medical Practice Act by the state in which he or she is practicing. An early, straightforward approach to this problem was to modify medical practice acts to authorize physicians who wished to do so to *delegate* to physician's assistants or nurse practitioners certain tasks that would previously have been considered the exclusive prerogative of the practicing physician.[13] In this manner, the Type A assistant is exempted from the limitations of medical practice acts "as long as the extender remains under the 'direction and supervision' of a duly licensed physician."[14] While classic in its simplicity, this approach is designed more for the immediate protection of the practicing physician and physician extender, but is not structured to further the legal and professional development of the physician extender. Moreover, the general delegatory approach fails to provide for the many contingencies inherent in a new and dynamic situation such as is presented by the physician extender movement. Indeed, it is of interest that many of the authorizing statutes followed passage of a much more specific piece of pioneering legislation in this area, the Colorado Child Health Associate Act of 1969.[15]

Ultimately, even in those states which initially authorized practice of physician extenders through a simple delegatory amendment to their medical practice act, the predominant pattern became one of much more specific legislation following the regulatory/authority model.

Regulation—Regulatory/Authority Model

As noted above, states are increasingly passing laws which not only authorize the limited practice of medicine by physician extenders, but which establish regulations for such practice, and place authority for implementing these regulations in the state boards of medicine and nursing for physician's assistants and nurse practitioners, respectively. As is noted in an excellent treatise of this entire subject appearing in the *Millbank Memorial Fund Quarterly*, with reference to physician's assistants, "the *regulatory-authority* model authorizes a state agency, generally the State Board of Medical Examiners, to develop and implement rules and regulations governing the education and practice of PAs."[16] The same may be said of the state boards of nursing vis à vis nurse practitioners. A recent review of state legislation noted that of 15 states with some form of delegatory amendment to their medical practice act, 13 of these passed a PA regulatory statute providing more detailed regulation of PAs. In these situations, the delegatory amendment has little utility once the regulatory legislation has been passed. In total, at the time of this survey, 39 states had PA regulatory statutes of some kind with virtually all states apparently moving in this direction.[17]

The question of "vicarious liability" or *respondeat superior* referenced in the previous section is not necessarily resolved by the regulatory-authority model of legislation. In point of fact, most statutes seem to require the physician's assistant, at least, to be an employee of a sponsoring, supervising physician. This is the case in Arizona. According to at least one author, however, it is possible under the regulatory-authority model to have entrepreneurially independent physician extenders contracting with physicians for services rendered, thus avoiding the doctrine of "vicarious liability" on the part of the physician. Such a situation is said to exist in Idaho, where a joint medical and nursing commission is responsible for regulating the practice of nurse practitioners. Presumably, in this setting the independent contractor model is a viable alternative.[12]

As in the case of Idaho, a supervisory body is typically invested with the responsibility of promulgating and administering regulations pertaining to the physician extender in question. In the case of Arizona and physician's assistants, this body is the combined boards of medical and osteopathic examiners, chaired by the Dean of the College of Medicine. Called the "Joint Board of Medical Examiners," this group has total responsibility for physician's assistants in the state of Arizona.

One of the first responsibilities of the board is to establish qualifications for certification as a physician's assistant in the state of Arizona and to

certify which applicants meet these qualifications. Generally done through a process of proficiency testing, Arizona (as do many other states) relies on candidates having passed the examination of the National Commission on the Certification of Physician's Assistants. In addition, in Arizona the candidate must meet a number of other qualifications such as having a good moral and professional reputation.

Increasingly common as a part of regulatory-authority legislation in this field is task definition for the physician extender. Typically, there is a requirement that this job description be submitted together with any application sent to the state for approval of a particular physician's assistant.[16] A review of the Colorado situation noted one possible drawback to this arrangement:

> By strictly defining the permissible functions, the public is given the greatest protection, but possibly at the cost of physicians being restricted from employing the Child Health Associate most effectively and Type A assistants using their training most appropriately.[14]

Arizona, in addition to spelling out quite specifically eight health care tasks which may be performed by a physician's assistant, requires that each PA application be accompanied by a job description. More liberal than some states laws, the Arizona statute permits the physician's assistant to include drug prescribing as an allowable task, assuming certain conditions are met (ie, the drug must be issued under the name and registration number of a supervising physician, must be prepackaged by the supervising physician or a pharmacist acting on the written order of the supervising physician, and no Class Two or Three controlled substances may be included). New York is noted to be particularly liberal in this regard, permitting PAs to prescribe drugs (with the exception of controlled substances) and to practice medicine generally without the constant personal supervision of a physician.[8]

Given the primacy of independence as an issue in the area of physician extender legislation, physician supervision becomes an extremely important part of that process. "Direction and Supervision" has traditionally not required the physical presence of a physician, but rather the overseeing and advising in the performance of specific functions.[5] Some, nonetheless, feel that "over the shoulder" supervision is the surest way to avoid criminal prosecution and therefore the best policy. "The further the deviation from this standard, the greater the risk of a criminal warrant being recommended."[18] Many case reports state the contrary, noting the successful use of physician's assistants in specialty and other practices without the constant monitoring of the supervising physician.[19] Legal opinions support the argument that "direction and control" do not require direct physical presence of the supervising physician.[20]

Arizona law states quite clearly that the supervising physician shall in all cases be regarded as the employer of the physician's assistant and be responsible for directing and supervising the PA's work. This law further provides for delegation of an agent by the supervising physician, should the supervising physician not be available. Specific provision is made in the Arizona law for remote placement of PAs, by requiring only that the supervising physician be in daily contact with any related PA through telephone, radio, or personal visit. There is the further requirement in the Arizona law that the supervising physician and physician's assistant shall meet personally at least once a week.

Because of the strong employer-employee relationship implied by many state regulatory-authority laws, these laws also may contain equally strong identification or disclosure requirements. That is to say, the physician's assistant must identify himself or herself as something other than a physician. This derives from the important legal principle of "informed consent," without which a patient may allege that battery has occurred.[7,11] An early observation concerning this disclosure requirement, which does not appear to have been borne out in practice, is that it would have a "chilling" affect on patient responsiveness, since other health care providers are not required to identify themselves in a similar manner.[16] In the case of Arizona, the law is quite specific, in the minds of some, insultingly so. It requires that at all times a PA shall wear a name tag with the designation of "Physician's Assistant" on it, and that the term "doctor" shall never be used in association with a physician's assistant, either verbally or in writing.

In addition to the foregoing requirements, state regulatory legislation includes provision for approval of training programs and requirements for

continuing education on the part of physician extenders. A 1977 review of nurse practitioner/physician's assistant training programs by the National Center for Health Services Research revealed a wide diversity of content, both within and between programs.[21] As noted in an earlier article:

> While most of the state regulations require that the PA complete an approved training program, there is substantial variability in the specific approaches taken in regulating the education and training process.[16]

Often such training programs are placed in medical colleges, with a possible consequence of "checking the development of this occupational category."[16]

In Arizona, the law relies upon the candidate having passed the certifying examination of the National Commission on the Certification of Physician's Assistants. No specific training program requirements are specified. There is, however, a requirement that each physician's assistant show proof that 50 hours of continuing education "certified by a national, state, or local medical society or association, or by a college or university" has been completed every year. This is a stated requirement for recertification. Further incentive is provided in this area by the National Commission on Certification of Physician's Assistants, with mandatory recertification every two years. This is dependent upon the PA having met continuing medical education requirements.

One final issue that should be noted in this section pertaining to the regulatory-authority model is that of reimbursement. If PAs are held to the same standard of practice as physicians, being their employees and under their immediate direction, it is logical for PA and physician fees to be the same for services rendered. Should, however, the PA wish to establish an independent standard of care, in the process of becoming an independent contractor, a different (presumably lower) fee schedule from that of the physician would be indicated.

Licensure—Independent Practice Model

The third phase in the potential development of physician extenders is professional licensure for independent practice. Licensure, as opposed to registration, confers a degree of professional recognition and responsibility upon the group being licensed. While licensure may or may not be associated with a supervisory requirement by the physician, it opens the door to independent practice. The very process of recognition and definition, however, also imposes restraints on what might otherwise be an evolving role for the new health practitioner. Accordingly, Curran argues that at this point in history, physician extenders should be regulated through more permissive registration than through licensure.[22]

The advantages and disadvantages of independent practice by the physician extender are basically the advantages and disadvantages of freedom vs responsibility. For the physician extender, the gain is one of freedom—freedom to practice independently of a supervising physician. A corresponding disadvantage is that the significantly greater responsibility that would accrue will mean more litigation and greater malpractice liability.

The corresponding advantage for the physician to an independent practice pattern by physician extenders is the reduction in "vicarious liability" through elimination of the *respondeat superior* understanding that exists at present. With a new standard of care emerging for physician extenders, they would relate to physicians not as dependent employees but as independent contractors.

A potential disadvantage for the physician, assuming a limited demand function in the marketplace, would be the possible displacement of the primary care physician by the physician extender. As noted by Chapman and Record:

> It may be that NHPs (New Health Professionals) eventually will replace general practice physicians, or create a separate rung in the hierarchy of health care providers, or carve out a distinct set of NHP services in primary care. Such a practice context would be analogous at law to that of optometrists, who have created their own standard of care as primary care providers, separate from the standard of ophthalmologists.[12]

It is interesting to note that optometrists have been in the forefront of efforts to limit the functioning of physician's assistants trained to work in the office of ophthalmologists (through the so-called Duffy Clauses).[23]

Nursing perhaps provides the best model of an expanding health profession, with possible implications for the evolving role of physician extenders. Until Florence Nightingale established the first school of nursing at St. Thomas' Hospital, England, in 1860, there was no formal training program for nurses.[24] Building upon a base of only 15 nursing schools 100 years ago (1880), nurses began an active campaign during the first part of the 20th century for state laws to register trained nurses.[25] Drawing upon the leadership of two national groups organized just before the turn of the century (the National League for Nursing and the American Nurses' Association), such progress was made that by 1923 all states in the union had nurse licensure laws on their books.[26]

The second phase in the development of nursing practice came around 1938 when the first mandatory practice act was passed in New York.[13] Two levels of nursing were here established, the registered and the practical nurse, and licensure was required. Only at this point did nursing begin to achieve a clear definition as a profession and pass beyond its initial role of healer and mother surrogate.[27] Perhaps less dramatic, but no less important, is the third phase of nursing evolution that was experienced in the 1970s and enabled nurses for the first time to take on certain diagnostic and treatment functions.

This latest phase in the development of the nursing profession has been hindered by a 1955 definition of nursing practice put forward by the American Nursing Association. The latter part of a longer definition concluded with the following statement: "The foregoing shall not be deemed to include any acts of diagnosis or prescription of therapeutic or corrective measures."[28]

Possibly pleasing to physicians and their constituents, this declaration tended to overlook the fact that "despite what the laws actually say, nurses for years have been making judgments and have been caring for patients in a variety of settings."[13] It is probably fair to say that even today there is some schizophrenia within the nursing profession over the degree to which nurses should be involved in diagnosis and treatment. There can be no doubt, however, that with respect to independence from control by the medical profession, there is little disagreement among nurses. They wish to operate under the direction of state boards of nursing and be professionally reviewed by members of their own profession. To the degree that this goal has been achieved, nurses have established the status of independent contractor and have reduced the "vicarious liability" of the physicians with whom they work.

To date, there has been no significant move by physician's assistants in this direction. Classified as Type A assistants along with nurse practitioners, physician's assistants have—at least to this point in time—staked their identity with the practicing physician, being content with regulatory legislation at the state level. In so doing, they have often found themselves in less conflict with organized medicine than have nurse practitioners, who have demanded a more independent status.

Doubtless, the future of each of these two categories of physician extenders will be influenced by the relative degree of independence that it has assumed for itself. Given the political lobby behind them, nurse practitioners may succeed in establishing an identity as independent of the primary care physician as optometrists are of ophthalmologists. In doing so, they will further cement their role as independent contractors. Physician's assistants, on the other hand, must decide whether to solidify and remain in their current position or eventually to strive for the same independent status.

In formulating a position on this important issue, physician extenders in the United States might well look at what has happened in other countries. When the supply of physicians has been limited, as in the case of the Sudan, physician extenders or substitutes have fared extremely well. When, on the other hand, the supply of physicians has increased, physician extenders have lost a considerable degree of their independence. A case in point is the Felcher movement in the Soviet Union, where the role of Felcher has shifted from a substitute to a complementary function vis-à-vis the physician.[29] Even in China where physicians are relatively less abundant than in the Soviet Union, the role of the barefoot doctor has been much more carefully structured and defined.[30]

A review of physician manpower supply and requirements in the United States from 1980 through 1990 indicates an oversupply situation may already exist and that this is likely to worsen over the decade.[31] Although primary care physicians are generally agreed to be in a shorter than desirable supply at the present time, it is

anticipated that their numbers will grow from 176,440 in 1980 to 257,730 in 1990, representing nearly a 50 percent increase as compared to a one third increase for all physicians.[32] It would appear, then, that the relative lack of primary care physicians today is in the process of correction and that this deficit may not be counted upon by physician extenders seeking to establish an independent, competitive role definition.

The one situation commonly cited in favor of a more independent role for physician extenders is the maldistribution of physicians in the United States. While there are 149 physicians in patient care per 100,000 population for metropolitan* areas and only 77 physicians in patient care per 100,000 population in non-metropolitan areas, this differential is markedly reduced among physicians in primary care fields. Here there are 51 physicians per 100,000 population in metropolitan areas vs 35 physicians per 100,000 population in non-metropolitan areas.[33] Thus, while over 85 percent of all practicing physicians are concentrated in metropolitan areas and are, as a consequence, maldistributed, the maldistribution of those physicians who are most susceptible to replacement by physician extenders is less marked. Accordingly, while state laws may continue to provide encouragement for placement of physician extenders in medically underserved areas (Arizona law states that "Physician's Assistants shall additionally be utilized to extend the availability of health care services in medically underserved areas of the state"), the current distribution and future growth pattern of primary care physicians make it unlikely that the independent component of these roles will be greatly expanded in the future.

Indeed, those physician extenders who recognize this changing pattern of physician manpower and learn from historical trends in other countries, may best be advised to follow one of two courses. The first is to fill a needed function as physician extender employee. Through the diverse state legislative process, it should be possible to arrive at a satisfactory description of function without ever moving into the independent practice model. The practical implications of such a course are that the physician extender would be subject to the control of the physician and allowed to exercise independent judgment only within certain clearly defined parameters. Since these physician extenders would be working as employees of physicians, fees for service performed by them would be the same as if those services had been carried out by the physician. The physician would retain "vicarious liability" under the doctrine of *respondeat superior* for actions of physician extender employees and these actions would be judged by a panel of practicing physicians.

The other path which could be taken by physician extenders at this time is to establish an independent practice model, but one sufficiently distinct from the primary care physician so as not to be seen as competitive. The critical issue in this model is the extent to which the independent practice physician extender would carry out diagnosis and treatment. To the degree that physician extenders seek independence in the areas of diagnosis and treatment of disease, it would appear that they are on a collision course with the medical profession. While quality of care arguments may be advanced on both sides of this controversy, it is likely that the real determinant will be economic advantage. Experience elsewhere would suggest that an increasing supply of physicians will ultimately result in even these physician extenders assuming a dependent role. In the meantime, however, conflict and polarization of physicians and physician extenders will characterize the encounter.

One important development could take place which would change the ground rules for physician extender expansion and which could influence the outcome of the debate. This would be the institution of national legislation, as opposed to the state legislation which is currently employed for both authorization and regulation. The National Conference of State Legislatures has recently polled key legislative health leaders throughout the United States to determine their response to the question: "What would your reaction be to a federal effort to supercede state licensing laws governing Nurse Practitioners and Physician's Assistants?" (Memorandum and Questionnaire to Key Legislative Health Leaders from Dick Mer-

*Actual or potential standard metropolitan statistical areas are defined as having a population of 50,000 or more. There are 300 such areas in the US at present.

ritt, Staff Director for Human Resources, National Conference of State Legislatures, December 28, 1979, pp 1-4). Response from the states was generally negative. After asking the question, "Should a national credentialing program be established?" in their comprehensive treatment of the subject of law and physician's assistants, Cohen and Dean answer that "given the significant maldistribution of health manpower in the country and the great variability in the training and utilization of PAs, it is appropriate that state agencies continue to have primary responsibility for PA approval."[16] It would appear premature to have pre-emptive federal legislation on this subject, if it should ever be indicated.

Given the present diverse pattern of state legislation, change and variety are the hallmarks of the Physician Extender movement. Such a climate presents an excellent opportunity to provide both physician's assistants and nurse practitioners with a stable legislative base, compatible with the reality of physician distribution and perceived self-interest. If the direction of new legislation is toward extending the limits of independent judgment by physician extenders, either as physician employees or as unique providers of care, the prospects for progress are bright. If the emphasis is on achieving independent status by physician extenders in the diagnosis and treatment of disease, confrontation with the physician community is inevitable and failure to achieve this objective is likely.

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