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THE PHYSICIAN'S ASSISTANT IN CALIFORNIA—A BETTER LEGAL FRAMEWORK

On September 17, 1970, the Governor of California signed Assembly Bill No. 2109.1 This new law creates, but only partially defines, a new category of paramedical personnel designated "physician's assistants" (hereinafter referred to as P.A.s). The bill has been described as a "dramatic breakthrough in the area of legislation aimed at permitting wide use of allied health personnel capabilities previously restricted."2 The statute's impact is dramatic because the functional role of the P.A. is left largely to the discretion of the California Board of Medical Examiners, whereas the functions of most other paramedical personnel are limited by statute.3 The new scheme is only temporary as it is the intent of the Legislature eventually to "establish a system of certifying or licensing physician's assistants so that the quality of the service is insured."4 This comment will survey the advantages and disadvantages, including the possible constitutional challenge, of the wide discretion given the Board of Medical Examiners. It will compare this temporary system with the traditional system of licensure, and will, in addition, examine some P.A.-related malpractice problems. It is this writer's conclusion that the basic scheme of the temporary system discussed herein should be retained in the permanent P.A. licensure system.

THE NEW LAW AND ITS BACKGROUND

The physician shortage should come as no surprise to the people of California. In the special election of June 2, 1970, they defeated Proposition 1, which would have provided needed funds for the expansion of California medical schools.5 Even had Proposition 1 passed, it is apparent it would not have adequately met California's share of the national shortage of one million health workers pre-

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3 CAL. BUS. & PROF. CODE §§ 1000-07, 2137, 2726 (West 1962).
5 Proposition 1 as it appeared on the ballot: "FOR BONDS TO PROVIDE UNIVERSITY OF CALIFORNIA HEALTH SCIENCE FACILITIES. (This act provides for a bond issue of Two hundred forty-six million three hundred thousand dollars $246,300,000)."
dicted for 1975. This shortage is one of medical skills. If some medical functions can be performed by new varieties of trained and supervised personnel, then this shortage may be alleviated. California has turned to the P.A. as a partial solution.

The P.A. was created at Duke University in 1965. Since then programs have been springing up prolifically throughout the United States. The concept of the P.A. has included both the generalist P.A., who would act as the general practitioner's "third arm," to specialist P.A.s in fields ranging from midwifery to surgical assistance. Some of the operational programs have no implementing or supporting legislation. However, it was not possible to utilize P.A.s in California without implementing legislation. In Magit v. Board of Medical Examiners, the court held that the defendant doctor was guilty of employing an unlicensed person, and aiding and abetting the administration of an anesthetic by unlicensed persons, even though the unlicensed personnel were foreign doctors of medicine with specialized training in anesthesiology—the area in which they had been utilized. Although these foreign doctors had been supervised by a licensed physician, the court stated:

In the absence of some statutory basis for an exception, such as those with respect to nurses and persons engaged in medical study or teaching, one who is not licensed to practice medicine or surgery cannot legally perform acts which are medical or surgical in character, and supervision does not relieve an unauthorized person from penal liability for the violation of statutes which, like section 2141 of the code, prohibit the unlicensed practice of medicine.

With the defeat of Proposition 1 and Magit's prohibition of the delegation of tasks which are medical or surgical in character, the need for legislative action became apparent.

Assembly Bill No. 2109 established a system whereby one or more approved physicians may delegate tasks to a P.A. who is specifically approved by the Board of Medical Examiners to func-

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9 See RN, October, 1970, at 43-46 for a complete listing of existing and proposed programs as of that date.
11 CAL. BUS. & PROF. CODE § 2392 (West 1962).
12 Cal. Stats., ch. 414, § 6, at 1377 (1937) (repealed 1965).
tion under the supervision of the approved physician(s). The guiding purposes behind the bill are to remedy the "shortage and geographic maldistribution of health care services in California . . . ." and "encourage the more effective utilization of the skills of physicians . . . ." by providing for the delegation of tasks to P.A.s. The Board of Medical Examiners is empowered to certify educational programs for P.A.s which meet standards published by the board. A physician who desires to employ a P.A. must submit an application to the Board of Medical Examiners. The application must describe the qualifications of the proposed P.A., the background of the physician(s), and the way in which the P.A. is to be utilized in the physician's practice. The Board will approve applications where the proposed P.A. is a graduate of an approved program and is "fully qualified by reason of experience and education to perform medical services under the supervision of a licensed physician."

THE PROBLEM OF GEOGRAPHICAL MALDISTRIBUTION

As noted above, one of the basic purposes of the law is to remedy the geographical maldistribution of health care services in California. It might well be asked whether or not the law will have such an effect. If P.A.s do find positions in rural areas, phy-

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15 Id. § 2510.
16 Id. § 2515(a).
17 Id. § 2515(c). 18 Id. § 2516.
19 Id. § 2516(a-c).
20 Id. § 2517.
21 For a county by county breakdown of the ratio of physicians to the general population, see California Medical Association, California's Physicians—December 1966 through July 1969—A Socio-Economic Report of the Bureau of Research and Planning (January, 1970). The figures, as might be expected, show that rural counties have a much lower ratio than urban counties. For instance, the number of physicians per 100,000 persons, as of July, 1969, was 48.2 in Del Norte County, 48.3 in Glenn County and 53.2 in San Benito County as compared to 455.9 in San Francisco County, 235.3 in Marin County and 183.8 in Los Angeles County. Concentrations of hospitals in some counties (e.g., San Francisco County) partially account for the high ratio. Presumably, however, a physician, whether or not associated with a hospital, gives more service to the county, or at least the general area, in which he resides than he does to outlying areas. Although there are no figures available, one may assume that medical personnel are also maldistributed within the metropolitan areas, with lower ratios in lower income areas, such as the "inner city." It might also be noted that although from December, 1966 to July, 1969 there was an increase of 7.2 percent in the total number of non-federal physicians practicing in California, there was a 0.9 percent decrease in the total number of general practitioners during the same period.

sicians, hopefully, will be free to spend more time on more demanding and complex tasks. However, if a proportionately larger number of P.A.s find positions in urban areas, then although the absolute level of patient care may improve in both areas, little progress will have been made in reducing the geographical maldistribution of health care services. Hearings were held by the Board of Medical Examiners for the purpose of gathering information and data required to implement the Physician’s Assistant program. At those hearings, the question was raised briefly whether, under the authority of Article 18, P.A.s could be sent to those areas where the major physician shortages exist. The subject was not pursued at length. In addition to the controversy surrounding the subject, there are several potential legal obstacles to the Board’s exercising such power. First, there is no specific provision in the bill authorizing such an exercise of discretion by the Board. Even if legislation authorizing a system of sending graduates of P.A. courses to particular areas were to be found constitutional, it is still possible that the making of a similar regulation by the Board under the present law would be an abuse of administrative discretion. The creation of any system involving predetermination of the P.A.’s (or any other professional’s) location of practice would appear to be an important change of policy. Generally, the legislature must fix basic policy, while the administrative body simply “fills in the details.”

Other problems may arise under the equal protection and due process clauses of the United States Constitution. Assuming that the P.A.s sent to particular areas would have lower incomes than the P.A.s allowed to practice in other areas, there must be an equitable and random method of choosing those P.A.s in order to avoid a violation of the equal protection clause. Some might claim that a law that allows for predetermination of a P.A.’s place of practice is a violation of the right to travel. Since a license to practice medicine is a valuable property right, it may be argued that such an infringement on that right would be violative of due process.

However, the seriousness of the inequities involved with the

22 The hearings were held on February 19 and 20, 1971, in San Francisco and March 1 and 2, 1971, in Los Angeles. For information concerning the transcripts, which, as of this writing, are not generally available, contact the Board of Medical Examiners.
23 It may be argued that even if the Board does have the power under Article 18 to send P.A.s to particular areas, such a function could be better handled by the legislature which is better equipped to assess the severity of maldistribution and administer a program of redistribution.
orderless dispersal of health manpower cannot be overlooked. Perhaps the easiest solution to the maldistribution problem would be employment of more government physicians under the Public Health Service or a similar agency. Federal or state legislative action could remove the pressing needs that would otherwise tend to shape judicial decisions. If the legislature does not act, strong precedent could be found to support severe limitations on the licenses of P.A.s, and other health care personnel, based upon the state's police power. It has been held that private property and contract rights must yield to necessary exercises of the state's police power. The police power is itself elastic and changes in scope according to the social and economic needs of the day. The state may exercise the police power in furtherance of the public health. The granting of a license confers no vested right and the licensee accepts it subject to power of the state to impose further regulations. This is not the place for a detailed perusal of this question. It is enough to say that the issue may be reduced eventually to a balancing of the competing interests: the public health versus a limitation on property interests and a certain loss of professional freedom.

CONSTITUTIONAL PROBLEMS

The discretion given the Board to approve physician's applications raises the possibility of an attack on the new law as an unconstitutional delegation of legislative power. The ability of the Board to limit the scope of practice of P.A.s may also raise this question. The problem is not with the federal Constitution. The validity of powers delegated to the Board by the legislature is a state constitutional question in so far as the separation of powers doctrine is concerned. There is no requirement in the federal Constitution that state governmental powers be distributed in one particular manner.

28 See 42 U.S.C.A. § 254(b) (West 1969) which takes a step in this direction by allowing the Secretary of Health, Education and Welfare to send Public Health Service personnel to areas with "critical health manpower shortages."
31 Lieberman v. Van De Carr, 199 U.S. 552, 554 (1905).
33 CAL. BUS. & PROF. CODE § 2516(c) (West Supp. 1971).
34 See CAL. CONST. art. 3, § 1.
The basic requisite for a valid delegation of “sublegislative” power to an administrative agency is that the legislature have the necessary power to legislate.\(^6\) There is no question that the legislature has the power to set qualifications and limit the functions of medical personnel.\(^7\) It has set qualifications for licensed medical categories in California and limited the functions of all but the physician who has an “unlimited license” to practice medicine.\(^8\) Can the legislature constitutionally delegate these functions to the Board of Medical Examiners?

Administrative agencies in California are limited in their powers to those expressly conferred by statute or those which may reasonably be implied to carry out express authority.\(^9\) In the past many courts have required that the delegated powers be limited by meaningful standards. The tendency during the past three or four decades, however, has been to uphold delegations with vague standards or even with no standards whatsoever.\(^4\) Although the California courts may not have explicitly accepted this dilution of the separation of powers doctrine,\(^4\) the cases show that the courts will permit state agencies to exercise very broad powers, whatever the label put upon them. The placing of power in an administrative agency, as opposed to the legislature, is especially necessary where a profession is involved and there is a requirement for expertise in the decision making process.\(^4\) In such a case, the agency is made up of experts (as is the California Board of Medical Examiners with eleven physicians out of the twelve members)\(^4\) and is particularly able to deal with the problem area.\(^4\) Because the field of public health is too critical to be limited by the nebulous doctrine of the separation of powers, California courts have consistently upheld the delegation of broad powers to medical boards, even to the extent of allowing the boards to set their own standards.\(^4\) Moreover, where the legislature has set forth the purpose of the enactment, the declaration

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\(^{39}\) Dickey v. Raisin Proration Zone, 24 Cal. 2d 796, 151 P.2d 505 (1944).


\(^{42}\) Ex parte McManus, 151 Cal. 331, 335, 90 P. 702, 703 (1907).

\(^{43}\) Ex parte McManus, 151 Cal. 331, 336, 90 P. 702, 703 (1907).

\(^{44}\) Ex parte Whitley, 144 Cal. 167, 77 P. 879 (1904); People v. Chong, 28 Cal. App. 121, 151 P. 553 (1915).
of purpose and policy may, in itself, provide a sufficient standard to guide the agency.\textsuperscript{46} To attack the delegation of powers to the Board to judge applications and determine the scope of practice of P.A.s would appear to be a reversal of the trend towards increasing the power and discretion of administrative agencies. In view of the special competence of the Board in these areas, the rationale behind such a reversal is not apparent.

However, the new law is not wholly without standards. The Board will approve applications by physicians only where the P.A. is a graduate of an approved program and is qualified by “experience and education” to function under the supervision of the applying physician.\textsuperscript{47} Such a broad test leaves much discretion to the Board, a necessity in an experimental scheme which is designed to allow for innovative educational programs.\textsuperscript{48} Nevertheless, it is a sufficient standard to ward off attacks on the law’s constitutionality.

Related to the Board’s power to accept or reject applications is its power to limit the tasks the P.A. may perform. As of this writing, the Board has not published any of the regulations called for by Article 18. There can be no doubt, however, that the Board has the power to make regulations defining the P.A.’s scope of practice. Besides specific authorizations to make regulations,\textsuperscript{49} Article 18 includes a clause which authorizes the Board to make such regulations as are “reasonably necessary to carry out the purposes of this article.”\textsuperscript{50} This is a standard which may guide the Board in determining a P.A.’s scope of practice. Physicians may delegate tasks to P.A.s where “such delegation is consistent with the patient’s health and welfare.”\textsuperscript{51} This standard, like the standard for acceptance of applications, is a broad one. However, where a board is composed of professionals, the imposition of a rigid standard by the legislature might rob the board of the discretion only it, not the legislature, has the knowledge to exercise responsibly.

MALPRACTICE PROBLEMS

The creation of the P.A. will open new areas of possible malpractice liability for the supervising physician as well as the P.A. himself. Some are relatively clear cut and may effectively be solved

\textsuperscript{46} Knudsen Creamery Co. v. Brock, 37 Cal. 2d 485, 234 P.2d 26 (1951).
\textsuperscript{47} CAL. BUS. & PROF. CODE § 2517 (West Supp. 1971).
\textsuperscript{48} Id. § 2510.
\textsuperscript{49} Id. §§ 2515(c), 2516.
\textsuperscript{50} Id. § 2522.
\textsuperscript{51} Id. § 2510.
by the Board's regulations. An example is the necessity of obtaining the patient's consent to medical treatment. If a patient consents to any treatment under the impression that he is being treated by a physician when, in fact, he is being treated by a P.A., he may claim his consent was based on a misrepresentation and was, therefore, vitiated. The result could be a suit for battery.\textsuperscript{62} It is well within the Board's power\textsuperscript{53} to require that P.A.s wear large badges designating themselves as physician's assistants. It may even require that a statement of consent be signed, at least at the patient's initial exposure to the P.A. Such regulations should effectively minimize misunderstanding and the litigation which misunderstanding invariably produces.

Other areas of possible malpractice litigation may not be as conducive to simple solution. A P.A. may perform medical services under the supervision of an approved physician.\textsuperscript{54} But how immediate must the supervision be? Clearly, the physician need not always be physically present.\textsuperscript{55} Routine tasks, such as the administration of inoculations, are often performed by unsupervised nurses, and could certainly be performed by unsupervised P.A.s. Other tasks, such as suturing, may, depending on the situation, be routine or quite complex. A third group of tasks, for example the delivery of babies, may be considered so uniformly delicate that, if such a task is ever delegated, the physician should always be physically present.

A physician may be liable for the negligence of his assistants and employees under the doctrine of \emph{respondeat superior}.\textsuperscript{56} He must exercise due care in selecting his assistants.\textsuperscript{57} May he also be negligent in not exercising a sufficient degree of supervision over a non-negligent assistant? If, for instance, a P.A. makes an error in judgment that the physician would (or should) not make, can the plaintiff claim that the physician was negligent in failing to supervise the P.A. adequately? In such a case the required degree of supervision would become an open question to be determined by the surrounding circumstances and the custom and practice of other physicians in supervising their P.A.s.\textsuperscript{58}

\textsuperscript{52} \textit{W. Prosser, Handbook of the Law of Torts} 106 (3d ed. 1964).
\textsuperscript{54} \textit{Id.} § 2512.
\textsuperscript{56} \textit{Ybarra v. Spangard}, 25 \textit{Cal. 2d} 486, 154 \textit{P.2d} 687 (1944); \textit{Ales v. Ryan}, 8 \textit{Cal. 2d} 82, 64 \textit{P.2d} 409 (1936).
\textsuperscript{58} \textit{See Chalmers-Francis v. Nelson}, 6 \textit{Cal. 2d} 402, 57 \textit{P.2d} 1312 (1936), where the court implied that, in light of existing custom and practice, a licensed nurse, acting
This precise problem will not arise if the P.A. is held to the same standard of care as the physician. If the physician would be expected to handle the situation satisfactorily, then the P.A. would also, and the physician would be liable under *respondeat superior*. There are conflicting views on the standard of care to which the P.A. should be held. Is the P.A. to be held to the same standard of care as a physician, since he will be performing tasks traditionally performed by the physician, or is he to be held to a lower standard of care based on his lesser qualifications? If he is held to a lower standard of care, does this suggest a net lowering of the quality of care the patient will be receiving? If he is held to the same standard of care, is this an accurate reflection of his skills as a P.A.?

Normally, medical personnel are held to that standard of learning and skill normally possessed by members of that same class of personnel in the same or similar locality under the same or similar conditions.\(^59\) There are arguments in favor of a lower standard of care for P.A.s than for physicians. To hold supervising physicians responsible under *respondeat superior* for a very high P.A. standard of care could increase the insurance rates which those physicians employing P.A.s would be required to pay and, thereby, discourage participation in the program by physicians.

Nevertheless, Article 18 provides strong reason to believe that P.A.s should be held to the same standard of care as physicians. P.A.s are to perform medical tasks where such performance would be consistent with a patient’s health and welfare.\(^60\) It seems unlikely that the patient’s health or welfare would benefit by being subjected to a lower quality of medical care. Surely this is not what the legislature intended. More likely, the intent of Article 18 is to free physicians to concentrate on more complex tasks by allowing them to delegate tasks which could be performed equally well by P.A.s.\(^61\)

To hold P.A.s to a lower standard of care than physicians would be legal recognition of a lowering of the quality of care patients

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under the direction and supervision of a licensed physician, may perform certain tasks which, without such direction and supervision, would constitute the illegal practice of medicine.


\(^61\) “Many physicians will tell you that some of the things they do can be performed by other well-trained and well-supervised persons.” Statement by Assemblyman Gordon Duffy, co-author of Assembly Bill 2109, June 15, 1970. The implicit rationale behind this statement is that these particular tasks can be performed equally well by P.A.s.
would be receiving. This would also remove a stimulus, which would otherwise be present, for the attainment of excellence in P.A. training programs. By holding the P.A. to the same standard of care as the physician, the doctrine of *respondeat superior* should work to maximize supervision. A physician will delegate only where he is sure the P.A. can do a physician-like job, and he will supervise carefully to make sure the P.A. is performing capably.

The question of the standard of care to which the P.A. should be held is therefore implicitly answered in Article 18. Under the authority of section 2522, which gives the Board the power to adopt such regulations as are reasonably necessary to carry out the purposes of the Article, the Board should include in its regulations a requirement that a physician delegate tasks only where the P.A. can perform as competently as the physician. The Board could even go so far as stating explicitly that the P.A. is to be held to the same standard of care as the physician. Even if the Board should not regulate so explicitly, the legislative intent behind Article 18 is clear. To hold the P.A. to a lower standard of care would be to ignore that intent.

**The Permanent System**

Section 2520(f) of Article 18 states that the Board shall, prior to January 1, 1972, submit to the legislature recommendations for establishing a permanent program of certification or licensure for P.A.s. It is this writer's conclusion that, with minor modifications, the scheme set forth by Article 18 should be maintained as the permanent system. The basic alternative to Article 18 is the traditional system of licensure. Such a system would include a statutory definition of the general functions the P.A. is to perform and of the educational requirements that must be met. The State Medical Practice Act lists the requirements for the licensing of physicians. Included are a detailed specification of the medical school curriculum and a listing of general subjects to be covered in the examination conducted by the Board. A physician's scope of practice is left opended. He may use "any and all other methods in the treatment of diseases, injuries, deformities, or other physical or mental conditions." Other medical personnel are subject to statutory limitations on their functions. A chiropractor is precluded

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63 See text accompanying notes 36-51, supra.
65 Id. § 2192 (West Supp. 1971).
66 Id. § 2288.
67 Id. § 2137 (West 1962).
from practicing medicine, as are nurses and laboratory technologists.

The rationale behind the traditional system is that it provides a guarantee that the licensed individual is competent to perform in the limited area prescribed by statute. There are drawbacks to such a system, however. The licensed individual may be very competent to perform functions not included under the strict statutory definition of his medical category. The valid question of the competence of the individual to perform a given task is thus converted into the question of whether it is legal for him to perform the task. Moreover, members of the various licensed occupational groups tend to guard jealously the functions statutorily limited to their medical speciality. The traditional licensing system may also limit career mobility. Where the system includes strict educational prerequisites, an individual with a particular license may be required to start at the very bottom of the educational ladder in order to meet the specific requirements of the more advanced medical speciality he wishes to pursue. He may receive very little, if any, credit for his previous education and experience. In addition, the detailed descriptions of required curricula in some licensure systems make no provision for rapidly changing educational needs. New technology, scientific progress, and changing patterns of medical care demand a flexible educational system. Furthermore, there is no guarantee that an individual, once licensed, remains qualified. No state attempts to prevent educational obsolescence by requiring some kind of continuing education of physicians. Few states require more than an application for reinstatement in the case of a lapsed license.

In sum, despite the safeguards it provides, the traditional system of licensure may deter a realistic allocation of medical tasks, inhibit career mobility, tend to create rigid educational systems, and provide an unreliable guarantee of competence.

68 Id. § 1000-07.
69 Id. § 2726.
70 Id. § 1240 (West Supp. 1971).
73 Id. at 73.
74 Model Legislation Project, supra note 8, at 12.
75 See CAL. BUS. & PROF. CODE § 2192 (West Supp. 1971).
Article 18 is a step away from the rather rigid licensure systems of the past. It gives the Board of Medical Examiners discretion to allow for needed flexibility in educational programs and task allocations. In fact, one of the stated purposes of the act is to allow for “innovative development” of educational programs. The act recognizes the desirability of promoting career mobility by encouraging the use of equivalency testing. It allows for individualized scope of practice based on the experience and education of the particular P.A.

A major factor in the irrelevance of traditional licensure is the existence of other quality controls—program accreditation is most important—which did not exist when the licensure system originated. Since the accrediting board, through supervision and controls, can remove any doubt that the particular educational program is valid, somewhat less weight may be given to initial competence and more weight may be given to the continuing relevance of the system.

In attempting to find an appropriate system for the P.A., the legislature was almost forced to innovate. If the P.A. was to fulfill his role as the physician’s “third arm,” his range of functions could not be arbitrarily limited. Each physician would use his P.A. according to his individual needs and practice. But, at the same time some control had to be exercised over the P.A. in the interest of the public’s health and safety.

In determining what system would be used, the legislature had a number of possibilities. Four states have statutes allowing for delegation of tasks to trained personnel as long as supervision is exercised by a physician or other licensed practitioners. Such statutes leave the question of the validity of the delegation solely to

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79 Id. § 2510.
80 Id. § 2515(b) provides that the board will consider the results of equivalency and proficiency testing and that “full credit” will be given to trainees for past education and experience in health fields. Since many of the potential P.A.s are medical corpsmen and nurses, it was felt that the law should allow them to receive credit according to their present skills and degree of knowledge. The question may arise whether a candidate can score high enough on the equivalency tests to fulfill the requirements of an approved program without actually taking any courses under that program. The credibility of the tests would be lessened if “full credit” were not interpreted literally. The Board of Medical Examiners has the responsibility of approving training programs for P.A.s. Therefore it must also have the responsibility for approving equivalency tests which may take the place of a part or all of an approved program. Once approved, these tests should be fully honored.
81 Id. §§ 2516(c), 2517.
82 Model Legislation Project, supra note 8, at 13.
the courts and offer minimal protection to the patient and the responsible physician. Another possibility was the creation of a "Committee on Health Manpower Innovations," which would be responsible for approving and defining new categories of paramedical personnel. Such a system would eliminate the need of going to the legislature for approval of each new category of personnel, but the great discretion given to the committee might leave it open to criticism as a policy-making agency.

The scheme which was eventually selected by the California legislature allows for more control than would a statute merely providing for general delegation of duties. The Board of Medical Examiners acts as the basic supervising agency and provides a first line of control before the courts. The new law creates an "Advisory Committee on Physician's Assistant Programs," but the Committee is "advisory" to the Board and has no specific independent powers. The success or failure of the new system obviously will depend on the ability of the Board of Medical Examiners to carry out its assigned functions.

The primary rationale for placing discretion in the Board is its flexibility and ease of action as compared to the legislature, and as noted above, the concentration of expert knowledge necessary to informed decision-making. The Board itself is immune from tort liability, so its members may make their decisions based solely on their professional opinions. Of course, potential P.A.s would have the right to relief from unfair Board decisions through the writ of mandate, so Board decisions could not be arbitrary. Perhaps the greatest drawback to such intensive use of the Board would be the demands on the members of the Board who maintain their practices while serving. The Advisory Committee on Physician's Assistant Programs should provide some help. If this problem were to become too severe, the best solution might be to provide for full-time Board members with appropriate salaries.

Because of the almost unlimited discretion vested in the Board, certain questions arise as to the Board's particular powers under Article 18. In theory, Article 18 can provide an even greater guarantee of initial competence than the traditional system of licensure.

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84 Model Legislation Project, supra note 8, at 24.
85 Id. at 21.
88 See text accompanying note 42, supra.
89 CAL. GOV'T. CODE § 818.4 (West 1966).
90 See Dare v. Board of Medical Examiners, 21 Cal. 2d 790, 136 P.2d 304 (1943); King v. Board of Medical Examiners, 65 Cal. App. 2d 64, 151 P.2d 282.
since the scope of practice can be limited to suit the skills of the particular P.A. But the submitted and approved scope of practice of the P.A. need not necessarily limit the P.A.'s functions. Section 2510 states that a physician may delegate tasks to his P.A. where such delegation is consistent with the patient's health and welfare. Whether or not the P.A. is limited to the approved functions in the physician's application is a question within the discretion of the Board of Medical Examiners. The argument in favor of allowing maximum flexibility in the certification system is that the P.A. should not be limited by the physician's description of the P.A.'s probable functions. Section 2516 does not specifically state that these functions are the only ones that the P.A. can perform. It simply calls for a description of the "way in which the assistant or assistants are to be utilized." Moreover, Section 2510 states specifically that tasks may be delegated "where such delegation is consistent with the patient's health and welfare." The liability of the physician under respondeat superior will act as a sufficient motive for the physician to delegate only where he is sure the P.A. is competent. Since the underlying rationale behind Article 18 is to provide needed flexibility in an experimental program, it would be inconsistent to limit the P.A. to any prearranged scope of tasks. It can also be argued that it would be almost impossible to list all the tasks the P.A. is qualified to perform.

The argument favoring more built-in safeguards is that some definite limit should be put on the P.A.'s range of functions. This can be done by limiting him to those functions listed by the physician in his application and subsequently approved by the Board. Should the P.A. increase his skills, the physician could submit a new list of functions to the Board for its approval. This, hopefully, would require the physician to consider each potential function of the P.A. prior to the time of actual delegation. It would also allow the Board to exercise its discretion. In addition to allowing the physician to submit a new list of functions whenever appropriate, the Board might also require the physician to submit a list of the P.A.'s functions periodically. This would be another means, in addition to vicarious liability, of requiring the physician to consider thoughtfully the P.A.'s role. The Board may also feel that, at least to begin with, there should be some limitations placed upon the P.A.

91 CAL. BUS. & PROF. CODE §§ 2516(c), 2517 (West Supp. 1971).
92 Id. § 2510.
93 Id. § 2516(c).
94 See text accompanying notes 65-82, supra.
95 This can be justified under CAL. BUS. & PROF. CODE § 2510 (West 1962), by concluding that delegation of duties not approved by the board would be inconsistent with the patient's health and welfare.
Such limitations could be useful as a record of the P.A.'s skills. It also would be a definite means of restricting P.A.s from areas where they have little skill. Many of the projected P.A. education programs are for specialists (e.g., pediatrician's assistant, surgical assistant). The P.A. could be limited to this speciality by limiting his scope of practice.

Should the Board decide to limit the P.A.'s functions in advance, the P.A. would presumably be guilty of the illegal practice of medicine and the physician of unprofessional conduct, if the P.A. performed outside the approved sphere. A listing of functions would probably have no malpractice implications in California.

CONCLUSION

A system similar to Article 18, giving broad discretion to the Board of Medical Examiners, can provide varying degrees of control over the P.A. Therefore, when the legislature considers what system should be made permanent, it need not assume that such a system need be any less protective to the public's health and welfare than a system of traditional licensure.

The basic scheme of Article 18 should be retained by the legislature. Some changes will be required. But the concept of moving away from the inflexible traditional licensure system is valid. Rather than remaking Article 18 in the likeness of the traditional system, the legislature may well consider remaking other licensure statutes in the likeness of Article 18.

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96 CAL. BUS. & PROF. CODE § 2377.5 (West Supp. 1971).
97 See Barber v. Reinking, 68 Wash. 2d 122, 411 P.2d 861 (1966), in which the Washington court found a presumption of negligence against a physician who delegated a task to a licensed practical nurse, where the particular task was a statutory task of professional nurses. But more states hold that mere absence of license is in itself no evidence of negligence. McDonald v. Foster Memorial Hosp., 170 Cal. App. 2d 85, 338 P.2d 607 (1959); Brown v. Shyne, 242 N.Y. 176, 151 N.E. 197 (1926); Grier v. Phillips, 230 N.C. 672, 55 S.E.2d 485 (1949).

Practicing without a license may be grounds for penal sanctions, however. See text accompanying notes 10-12, supra.
98 CAL. BUS. & PROF. CODE § 2514 (West Supp. 1971) restricts the P.A. from performing services in the areas of measuring vision, fitting lenses or frames, and dentistry and dental hygiene. These limitations are inconsistent with Article 18, under which a P.A. could perform complicated tasks if he acts under the supervision of an approved physician (assuming no other limitations by the Board).
99 As of this writing, bills modeled on A.B. 2109 have been introduced in at least two states (Michigan and Florida), testifying to the common need of finding a better system.