MEDICAL BOARD OF CALIFORNIA
Executive Office

ADVISORY COMMITTEE ON
PHYSICIAN RESPONSIBILITY IN
THE SUPERVISION OF
AFFILIATED HEALTH CARE
PROFESSIONALS

October 20, 2010

2005 Evergreen Street
First Floor Hearing Room
Sacramento, CA 95815
916-263-2389

AGENDA
11:00 a.m. – 1:00 p.m.
(or until the conclusion of Business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE
If a quorum of the Board is present, members of the Board who are not members
of the Committee may attend only as observers.

1. Call to order -- Dr. Moran

2. Roll call

3. Public comment on items not on the agenda
   Note: The Board/Committee may not discuss or take action on any matter raised during this public comment
   section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code
   Sections 11125, 11125.7(a)]

4. Approval of Committee meeting minutes of June 23, 2010 -- Dr. Moran

5. Update of the status of SB 1150 (Negrete McLeod) and AB 2566 (Carter) -- Ms. Simoes

6. Legal staff review of relevant laws and regulations within the Medical Practice Act regarding
   what constitutes the practice of medicine, the unlicensed practice of medicine, and corporate
   practice considerations -- Mr. Heppler and Ms. Scuri

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and
surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote
access to quality medical care through the Board's licensing and regulatory functions.
7. Scope of practice questions regarding mid-level practitioners and physicians –

A. Board of Registered Nursing, Miyo Minato, M.N., R.N., Nursing Education Consultant

- What is the scope of practice of nurse practitioners and registered nurses?

- Can nurse practitioners and registered nurses engage in independent practice? If so, when and where and under what authority?

- What are Standardized Procedures? How are they developed? What implications do they have with respect to physician oversight?

- Can registered nurses prescribe dangerous drugs and devices without a physician performing an appropriate prior examination?

- When a patient is treated by a registered nurse, must a supervising physician see the patient prior to delegation of treatment?

- What is the role of the supervising physician with respect to registered nurses according to current regulation statutes?

- May a supervising physician be offsite?

- Can nurse practitioners supervise registered nurses? What are the statutes relevant to this relationship? Can they perform a good faith exam and then delegate treatment to a registered nurse? What is the responsibility of the supervising physician in this scenario?

B. Physician Assistant Committee, Steven Klompus, Chairperson of the Committee

- What is the scope of practice of physician assistants?

- Can physician assistants prescribe dangerous drugs and devices without a physician performing an appropriate prior examination?

- Can physicians delegate prescriptive authority to a physician assistant without an appropriate prior exam?

- Can a physician assistant engage in independent practice? If so, when and where and under what authority?

- Can physician assistants prescribe dangerous drugs and devices without a physician performing an appropriate prior examination?

- Can physicians delegate prescriptive authority to a physician assistant without an appropriate prior exam?
• Can a physician assistant engage in independent practice? If so, when and where and under what authority?

• What is the role of the supervising physician with respect to physician assistants according to current regulations and statutes?

• Can physician assistants supervise registered nurses? What are the statutes relevant to this relationship? Can they perform a good faith exam and then delegate treatment to a registered nurse? What is the responsibility of the supervising physician in this scenario?

8. Does the Committee wish to make any recommendations for action items to Board staff, a Board Committee, or the full Board about the role of physicians, such as in delegating diagnosis/treatment to registered nurses, physician assistants, and nurse practitioners?

9. Future agenda items and meeting dates

10. Adjournment

NOTICE: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Cheryl Thompson at (916) 263-2389 or email cthompson@mbc.ca.gov or send a written request to Ms. Thompson at the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak.

For additional information call (916) 263-2389.
Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals

Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815

June 23, 2010

MINUTES

Members of the Committee Present:
Mary Lynn Moran, M.D., Chair
Jack Bruner, M.D.
Beth Grivett, P.A.
Paul Phinney, M.D.
Harrison Robbins, M.D.

Members of the Committee Absent:
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.
Suzanne Kilmer, M.D.
James Newman, M.D.

Audience:
Lydia Bauruer
Yvonne Choong, California Medical Association
Candis Cohen, MBC Information Officer
Janie Cordray, MBC Research Director, Staff to the Committee
Frank Curry, California Citizens for Health Freedom
Norman Davis, Attorney
Bryce Docherty, The Docherty Group
Jennifer Hatfield, Capitol Health Services
Kurt Heppler, DCA Legal Counsel to the Committee
James Kojian, M.D.
Christina Lee, California Medical Association
Ross Locke, MBC Business Services Office
Tim Madden, California Society of Plastic Surgeons
Kathleen McCallum
Rosielyn Pulmano, Senate Business, Professions & Economic Development
Agenda Item 1  Call to order

Dr. Moran called the meeting to order at 11:05 a.m.

Agenda Item 2  Roll call

Members present and absent are reflected above.

Agenda Item 4  Approval of minutes of April 29, 2010 meeting

It was moved (Bruner) and seconded (Phinney) that the minutes of the committee’s April 29, 2010 meeting be approved; the motion was adopted unanimously.

Agenda Item 3  Public comment on items not on the agenda

Frank Cuny, executive director, California Citizens for Health Freedom, asked if a patient is seeing a doctor as well as an alternative practitioner, and the patient wants advice from the physician, can the physician comment? He asked for a mechanism for a cooperative relationship so that the physician is not considered to be supervising the alternative practitioner, but the physician may communicate about the patient’s care. He suggested the committee might want to consider this issue in the future.

Louise Timmer, immediate past president, American Nursing Association of California, brought complaint information to the committee’s attention, and Ms. Cordray said the Board would open a complaint on the matter.

Agenda Item 5  Presentation regarding current laws and regulations relating to supervision and delegation of procedures to non-physicians

Ms. Cordray announced that she is retiring as of this date, and that Candis Cohen would be staffing the committee. Questions and comments regarding future meetings should be directed to her.

She noted that the Board began its work in this area in 1997 with its Committee on Plastic and Cosmetic Surgery, following cases involving deaths after liposuction. The Board published a formal opinion regarding the use of lasers that raised the ire of laser companies and some physicians, who thought anyone should be able to use them. The laws and
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regulations are the same as in 1998. She also mentioned the forums in 2007 and 2008 with the Medical Board and the Board of Registered Nursing that confirmed that almost all of the concerns people had about safety already are covered by laws and regulations that need to be enforced. The forums confirmed violations of corporate practice laws, payments for referrals and fee-splitting, advertising-statute violations, and in some cases, a total absence of physician supervision. She concluded that many of these problems are already illegal and that we do not need new legislation nor regulation, just enforcement.

Dr. Moran thanked Ms. Cordray for all of her work. She then brought to the attention of the committee Business and Professions Code sections 2242(a) and 4022, dealing with prescribing without an appropriate prior exam and medical indication, and noted that current law allows for delegation of prescriptive authority to physician assistants and nurse practitioners, and not RNs. She cited these as among many of the laws that make some of the current practices outside the standard of care.

Ms. Cordray noted for the record that the reason nurses were not specifically invited to speak at this meeting is that the committee’s purpose is to look at physician responsibility and the Medical Board has no jurisdiction over nurses. Physician assistants are involved in today’s meeting because the Physician Assistant Committee is under the jurisdiction of the Medical Board.

Dr. Bruner asked if any new laws are necessary, and Ms. Cordray replied that aggressive advertising and marketing have been a constant problem, e.g. use of terms “satisfaction guaranteed” or “as low as.” She suggested sanctions for advertising violations might be put on the committee’s agenda at some point. Also fee-splitting in her experience is a problem. She suggested greater enforcement in these areas.

Dr. Moran called for public comment.

James Kojian, M.D. said that he has been very active in this area for many years, and trains nurses in California. He brought a complaint to the committee’s attention; Ms. Cordray agreed to discuss it with him. Regarding med spas and physician supervision, he said the most important point is injector competence, regardless of who the practitioner is. He has seen incompetence in nurses in this area due to a lack of “up-front injector training.” Also there are no laws as to who can certify whom. He proposed physicians be the only persons allowed to train nurses on the use of injectors, and over an eight-hour period, and proposed a required, written certification “Botox exam.”

Norman Davis, health care attorney, spoke about seven points he thought should be considered by the committee. They dealt with why the issues of delegation and scope of practice are being considered solely regarding the cosmetic and aesthetic field of medicine; what real collaborative efforts besides the forums have been taken between the Medical Board and the Board of Registered Nursing per Business and Professions Code section 2023; if additional regulations are necessary, should they not be applicable in all practice settings if new standards are adopted, are all physicians willing and able to comply, and what agencies will regulate this; what about corporate practice issues; is this discussion really a turf war among professionals wanting to reduce competition among those performing minor aesthetic procedures outside the office setting; and over the past several years, the Medical Board’s enforcement program has tended to mix and match issues such as scope of practice, unlicensed activity, aiding and abetting the unlicensed practice of medicine, violation of the corporate practice of medicine and the risk of patient harm.

Missey McCallum, Northern California Aesthetic Nurses Association, agreed that training guidelines would be desirable because nurses in the aesthetic field want it. She said she feared “incrementalism,” nurses being able
to perform certain functions but not others without a physician being present, and believes new guidelines in the aesthetic area are not necessary. If there are limits on what nurses can do without physicians being present, especially in this time of physician shortages, it would unduly limit nurses’ established scope of practice. Advertising is a concern and should be regulated.

**Agenda Item 6**  
Update on the status of SB 1150 (Negrete McLeod), and other issues of importance to the Senate Business and Professions Committee

Jennifer Simoes, Medical Board chief of legislation, noted that this advisory committee had been established at the request of Senator Negrete McLeod. SB 1150, introduced this year by Senator McLeod, would impose various requirements related to health care practitioner advertising, cosmetic surgery, outpatient settings and accreditation, and the Medical Board has a support position. She introduced Rosielyn Pulmano of the Senate Business and Professions Committee.

Ms. Pulmano noted that SB 1150 has a provision that requires the Medical Board, on or before January 1, 2012 to adopt regulations regarding the appropriate level of physician availability needed in settings using lasers or intense pulse light devices. This part of the bill was introduced to addressroving physicians or physicians who enter into contracts with med spas to serve as a medical director in name only and are never available, even in emergencies. Senator McLeod believes physicians who sign up with med spas or have ownership interests should be available for consultation and should have oversight responsibilities and direct patient contact. Senator McLeod also would like the committee to look at the issue of physicians assuring that allied health professionals are trained and competent to promote patient safety.

Dr. Moran noted per Business and Professions section 2264, a physician may not order a treatment or drugs without an appropriate prior medical exam, unless specifically delegated and defined in the protocol with a nurse practitioner and a physician’s assistant. A physician must do an appropriate exam.

**Agenda Item 7**  
Presentations by organizations regarding under what circumstances is it appropriate to delegate the performance of procedures; and is it legal or appropriate to delegate to non-physicians the selection of patients and procedures and, if so, under what circumstance?

Abel Torres, M.D., American Society of Dermatologic Surgery, addressed the issue of under what circumstances it is appropriate to delegate cosmetic procedures. He said that the criteria should be that the delegating physician is properly trained in all of the procedures that he/she delegates. That delegating decision should be qualified by residency training, and/or preceptorship, and/or appropriate course work. The physician should have an extensive understanding of continuous medicine and surgery and the anatomy involved, the indications for the procedures, and the pre-and post-operative care involved in the treatment. Delegation should be done to certified or licensed allied health professionals where the physician is physically present on site, immediately available, and able to respond promptly to any questions or problems while the procedure is being performed. The physician also should perform a good faith exam prior to the procedure, and a medical record should be kept. The allied health professional to whom the procedure is delegated should possess a knowledge of continuous medicine, document the training in the procedure, the indications for the procedure, and the pre-and post-operative care. Additionally, the Medical Practice Act authorizes physicians to diagnose mental and physical conditions and to use drugs on human beings, to sever or penetrate tissue, to choose the treatment to be done, to use other methods of treatment. The treating of cosmetic conditions is medical care. Only after a physician makes these diagnoses and an order or delegation of services agreement may physicians assistants,
medical assistants, or nurses proceed. Aftercare is important too, as patients’ conditions change. Should it be legal or appropriate to delegate to non-physicians the selection of patients and procedures? No, there have been too many adverse outcomes in such instances.

Jonathan Sykes, M.D., California Society of Facial Plastic Surgery, American Academy of Facial Plastic Surgery, said everyone in the room wants honesty to the public, qualified, trained practitioners doing the work so patient safety is optimized, and “we want to obey the laws.” Or; “if the laws are bad, we want them changed.” Since the practice of medicine by physicians is regulated by the Medical Board and what nurses may do is regulated by the Board of Registered Nursing, those two boards should get together and talk about who should do what and how they should do it. He spoke about what is “direct supervision,” mentioning an issue of the Medical Board’s newsletter dated August 2007 that said it could not be a designated doctor who signed the charts once a month but didn’t have true supervision. He and his societies agree, but the Medical Board and the Board of Registered Nursing may interpret this differently. “Training” is not defined. He also sees no correlation between marketing and quality of care. Some people over-market, and the Medical Board should have mechanisms in place to handle that. He views funding for enforcement as a major issue, and thinks a plan should be made for better enforcement.

Tim Madden, California Society of Plastic Surgeons, said delegation of performance of procedures is relatively clear, as described by Dr. Torres. As to what procedures can be delegated and when that is appropriate, that comes down to the level of training and education of the person delegated to. The training and education of physicians themselves is important. Many physicians doing the delegating are not trained and do not understand the procedures they are delegating to mid-level practitioners. Often the mid-level practitioners do not have the training, either, although the ultimate responsibility is with the physician. As to the delegation to non-physicians the selection of patients and procedures, it is the responsibility of the physician to meet with the patients, do an examination, and determine what procedures should be done.

Dr. Moran said the state of California issues a general license, and physicians legally may practice any form of medicine, but as far as delegating, especially with physician assistants and nurse practitioners, the delegation should be in the field that the physician normally practices. The question becomes should there be some legislation about delegation of procedures and what the requirements of the delegating physician should be?

Ms. Cordray said this would always be a moving target, but when taken out of the cosmetic arena and put in some other specialty, she noted that procedures and devices change, and that practices in some specialties vary by location in the state. To be a competent supervisor, one must be competent in the area of medicine that one is delegating procedures. Department of Consumer Affairs’ Legal Counsel Kurt Heppler asked that this discussion be held until all the presentations had been heard. Ms. Cordray asked if the Board would have the regulatory authority to promulgate a regulation to define what was needed as far as specialty as in a physician assistant regulation. Mr. Heppler said he would have to research that question. Ms. Cordray suggested at the committee’s next meeting Legislative Counsel be asked to opine of the Board’s regulatory authority; to tell the committee what it may already do and what would require legislation.

Dr. Phinney had a question for Mr. Madden: Given that new procedures continually develop and new practitioners may or may not be trained in the new procedures, he deduced from Mr. Madden’s remarks that what a mid-level practitioner would be authorized to do would depend on the training of the individual at that time and may change over time in different situations. Mr. Madden said yes, so as medicine advances physicians are expected to keep up with it. Dr. Phinney asked further if what a mid-level practitioner does changes, e.g., if his/her supervising physician were on vacation and the substituting physician were not trained
in the same area, and Mr. Madden agreed, the substituting physician could not delegate and could not be the supervising physician.

Dr. Sykes noted that one reason aesthetic medicine has such problems is that it is done largely outside of hospitals and other credentialing facilities. He is personally aware of many physicians who are supervising in this area and just lending their licenses, with no expertise in aesthetic medicine.

Beth Grivett, physician assistant who handles legislative affairs for the California Academy of Physician Assistants and is a member of the committee, said that by law PAs must have a delegation of services agreement to practice in California, and “physician availability” is defined in that agreement for that practice, but does require physician availability at all times, including on request of the patient or the PA. An emergency backup plan is required, and the agreement defines procedures and protocols specific to the practice. Any physician in California can supervise a PA as long as he/she is in good standing with the Medical Board. PAs are an agent of the supervising physician, and PA orders are treated by regulation as if they were given by the physician. Supervising physicians may supervise up to four PAs at a time in the state. PAs only may perform duties customary to that office, and those the physician deems the PA competent to perform. The physician must be available on site or by telecommunication. There is a minimum of 5 percent chart co-signature and review. Chart co-signature must occur within seven days if a Schedule 2 drug is ordered. PAs’ most common training is in a PA program, with respect to a procedure in which the PA is untrained, if a physician is physically present and supervising that procedure until the PA is competent, California law considers that adequate training. Physicians cannot delegate to PAs the supervision of medical assistants. The only exception is legislatively designated clinics. PAs can perform good faith examinations, develop a differential diagnosis and treatment plan, and delegate procedures to other allied health care professionals, including nurses. PAs also are trained in the selection of patients for specific procedures. PAs may obtain informed consent, but may not perform procedures if a patient is under general anesthesia.

Harrison Robbins, M.D., committee member and representing the California Academy of Cosmetic Surgeons, said everything he had wanted to say was said well by Drs. Torres and Sykes, and he agreed with them. He disagreed, however, with Ms. Cordray to the extent that the committee could compare and make decisions with all of medicine. Patients make decisions, hopefully after informed consent by physicians. To determine the answers to questions posed at this meeting, physicians and nurses must communicate and work together. He said aesthetic medicine may not legally be practiced in med spas.

Dr. Kojian said the terms “delegation” and “supervision” had been used numerous times, but he reiterated that the key issue is injector competence. The State of California should define that and keep it at a very high standard for all injectors.

Dr. Moran noted during this meeting, there had been a few specific mentions of violations of the Medical Practice Act, indicated that a Medical Board investigator was present in the room with complaint forms, and encouraged those who had such information to provide it to the Board.

**Agenda Item 8 Discussion of the presentations and consideration of the Committee’s next steps**

Dr. Moran thanked everyone for their input, noting it was extremely valuable and helpful. Supervision is a hot-button issue, underlying that is the lack of enforcement of existing laws. If existing laws were better enforced, that would eliminate a lot of the problems in this area. She asked for a discussion of ways to enhance enforcement, noting that would take a meeting of its own. She asked staff to look into definitions of supervision
of non-physicians by physicians that exist in other states, although she did not want to take up that issue at the committee’s next meeting. She wanted to start with enforcement of current laws with an introduction of possible supervision ideas, if there is time at the next meeting. At the meeting after the next one the committee will tackle the very sticky issue of supervision.

Tricia Hunter, American Nurses Association, California, said under standardized procedures there are nine steps required for collaboration among a physician, a nurse, and the health facility they work in that define education, emergency procedure, recertification – all are clearly defined. She said she believed we have sufficient laws that just are not being enforced. The law is clear on when nurses take an order that they cannot take broad orders; orders must be very patient-specific. The Board of Registered Nursing is also clear on this and supportive about how delegation works and she saw no conflict in how that board interprets most of the laws that this committee has discussed. She encouraged collaboration.

Dr. Moran asked about Business and Professions Code section 2725, the Nursing Practice Act, and said the committee would review that for the next meeting, and Ms. Hunter noted it has very clear guidelines and both agreed that being aware of the relevant nursing laws would be helpful.

John Valencia, Wilke, Fleury et al. for the American Society for Dermatologic Surgery, agreed with Ms. Hunter that this is a question of enforcement of clear guidelines for nurses and physicians. He recommended that the committee invite the California District Attorneys Association and the Municipal City Attorneys Association that represents city attorneys because all have consumer protection divisions and would be good partners in educating the committee regarding their case-assessment process. Other law enforcement officers like Jan Scully, Sacramento County district attorney, have experience in enforcing this body of law.

Mr. Heppler asked Dr. Moran to confirm that she is directing that a subsequent meeting include having a presentation of the Board’s enforcement on this issue; that staff do a review of availability and supervision in other states; and that the city law enforcement agencies described above be invited to make a presentation as they see fit. Ms. Cordray suggested that Dr. Moran meet with Ms. Cohen and work on a calendar of such future plans. Dr. Moran agreed. Mr. Heppler offered to research and recommend to the committee at its next meeting what regulations they may need as a result of their findings to date.

Dr. Bruner asked if enforcing the Medical Practice Act were difficult due to budgetary restraints and if the Board could be as effective as it would like while current budget problems prevail. Medical Board Executive Director Linda Whitney said the Administration and the Legislature had just approved the Consumer Protection Enforcement Initiative, which will put more emphasis on the review of complaints and the “up front” part of the enforcement process, so our investigators will be more available to review complaints. She also mentioned the Board’s Operation Safe Medicine (OSM) and that the Board is requesting that its functions be extended beyond the two-year pilot. One of the activities OSM is interested in is unlicensed activity, and also corporate practice issues. She said she hoped the extension of OSM would be approved this fiscal year.

Agenda Item 9 Future agenda items and meeting dates

Mr. Heppler asked Dr. Moran to ask if there were any objections from the committee in proceeding in the direction set forth, or any other issues the members would like to have placed on the agenda. She noted that no date had yet been set for the committee’s next meeting.
Agenda Item 10    Adjournment

Dr. Moran adjourned the meeting at 1 p.m.
To the Members of the California State Assembly:

I am returning Assembly Bill 2566 without my signature.

I vetoed a similar measure last year. The reason for the veto remains the same. Existing law already addresses the issues highlighted by the sponsors and author. The real problem is that the sponsors want enforcement of this issue moved up on the prioritization of enforcement issues pending with the Medical Board (Board). California currently ranks 41st in the county for taking serious disciplinary action against doctors and this bill attempts to move those serious disciplinary actions behind businesses that operate "medi-spas" providing skin peels, dermabrasion and laser hair removal.

Good doctors are the backbone of our health delivery system. I believe the members of the Board want to protect patients. I just don't agree that the Board's time is better spent on medi-spa enforcement when other physicians should be more quickly investigated and prohibited from practicing medicine when they have caused serious patient harm or death.

Sincerely,

Arnold Schwarzenegger
MEMORANDUM

DATE | October 18, 2010
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TO | Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals
FROM | Kurt Heppler
Senior Staff Counsel
Legal Affairs
SUBJECT | Questions and Answers

ISSUE

This memorandum addresses issues surrounding the practice of medicine, the unlicensed practice of medicine, and the Medical Board of California's (Board) power to adopt regulations. The Board’s Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals (Committee) met recently and some substantive questions arose regarding these issues.

BACKGROUND

The Board is the state agency charged with the responsibility of issuing physician’s and surgeon’s certificates (medical licenses) to qualified applicants as well as disciplining those physicians who engage in unprofessional conduct.¹

At the last meeting of this Committee, questions arose regarding the Board’s power or authority to promulgate regulations. It is critical to understand the difference between statutes and regulations. Statutes are passed by the California Legislature and signed by the Governor; they are the framework or skeleton from which a state agency operates. Regulations are rules that are adopted to add flesh to the statutory skeleton. In fact, the purpose of a regulation is to implement, interpret or make specific a statute. However, a regulation cannot expand or alter the scope of statute. If it does, it is void. The test for determining if a regulation is valid consists of two parts: 1) The regulation is consistent and not in conflict with existing statute, and 2) it is reasonably necessary to effect the purpose of the statute. Of course, there must be sufficient statutory authority for the agency to promulgate the regulation.

¹ For the purposes of this memorandum, a license also includes a registration, certificate, or other means to engage in a business or profession regulated by the Business and Professions Code.
Another way to look at the relationship between statutes and regulations is that a statute would be the roof and structure of a building and the regulations would be the contents of the building. To be valid, the agency’s regulations must fall under the statute’s roof. The most recent example of a Board regulation that implemented a statute is the Notice to Consumers rule adopted by the Board. That regulation made specific the requirements of section 138 of the Business and Professions Code (Code)\(^2\), which obligated agencies with the Department of Consumer Affairs to adopt a mechanism by which the public would be made aware that a practitioner was licensed by a health care board.

**SPECIFIC QUESTIONS RAISED BY THE COMMITTEE**

1. What is the definition of the practice of medicine?

   Section 2051 of the Code provides:

   “The physician’s and surgeon’s certificate authorizes the holder to use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions.”

   Similarly, section 2052 of the Code provides:

   “(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment in the state prison, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.
   (b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.
   (c) The remedy provided in this section shall not preclude any other remedy provided by law.”

   Section 2053.5 provides:

   a) Notwithstanding any other provision of law, a person who complies with the requirements of Section 2053.6 shall not be in

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\(^2\) All further statutory references are to the Business and Professions Code unless otherwise indicated.
violation of Section 2051 or 2052 unless that person does any of the following:
(1) Conducts surgery or any other procedure on another person that punctures the skin or harmfully invades the body.
(2) Administers or prescribes X-ray radiation to another person.
(3) Prescribes or administers legend drugs or controlled substances to another person.
(4) Recommends the discontinuance of legend drugs or controlled substances prescribed by an appropriately licensed practitioner.
(5) Willfully diagnoses and treats a physical or mental condition of any person under circumstances or conditions that cause or create a risk of great bodily harm, serious physical or mental illness, or death.
(6) Sets fractures.
(7) Treats lacerations or abrasions through electrotherapy.
(8) Holds out, states, indicates, advertises, or implies to a client or prospective client that he or she is a physician, a surgeon, or a physician and surgeon.
(b) A person who advertises any services that are not unlawful under Section 2051 or 2052 pursuant to subdivision (a) shall disclose in the advertisement that he or she is not licensed by the state as a healing arts practitioner.”

Section 2053.6 of the Code provides:

“(a) A person who provides services pursuant to Section 2053.5 that are not unlawful under Section 2051 or 2052 shall, prior to providing those services, do the following:
(1) Disclose to the client in a written statement using plain language the following information:
(A) That he or she is not a licensed physician.
(B) That the treatment is alternative or complementary to healing arts services licensed by the state.
(C) That the services to be provided are not licensed by the state.
(D) The nature of the services to be provided.
(E) The theory of treatment upon which the services are based.
(F) His or her educational, training, experience, and other qualifications regarding the services to be provided.
(2) Obtain a written acknowledgment from the client stating that he or she has been provided with the information described in paragraph (1). The client shall be provided with a copy of the written acknowledgement, which shall be maintained by the person providing the service for three years.”
(b) The information required by subdivision (a) shall be provided in a language that the client understands.

(c) Nothing in this section or in Section 2053.5 shall be construed to do the following:

1. Affect the scope of practice of licensed physicians and surgeons.

2. Limit the right of any person to seek relief for negligence or any other civil remedy against a person providing services subject to the requirements of this section.”

The Board has addressed the unlicensed practice of medicine in the elective cosmetic arena with the adoption of the Basile case as a precedental decision. In Basile, the physician was associated with a medical office that utilized an intense pulse light device to treat various conditions. The device also contained a laser to treat other conditions. The device penetrated human tissue to treat blemishes and other conditions. “In short, the use of IPL (intense pulse light) and laser clearly involves penetration of human tissue and therefore falls within the scope of medical practice.” (Basile, page 5.)

Respondent permitted his wife, who was an unlicensed person, to use the device to treat patients. Respondent, by allowing such actions, was found to have committed unprofessional conduct and to have aided and abetted the unlicensed practice of medicine. Regarding the practice of medicine, it is important to note the Board does not issue specialty or limited licenses except in the case of a disabled physician who seeks a limited license.

2. Is there a statutory or regulatory definition of a ‘medical spa’ or ‘medi-spa’ within the Medical Practice Act or its attendant regulations?

No. Remember, the terms above contemplate a place or a physical location for the practice of medicine, which generally speaking the Board does not license. However, Committee members should be aware that there is some interplay between a physical location, fictitious name permits, and the statutory bar on the corporate practice of medicine. With certain exceptions, if a physician wants to practice under a name other than his or her licensed name, a fictitious name permit is required. (See §§ 2285, 2415.) This permit needs to be placed at the location where the services are to be provided so that the public is informed of the physicians ‘behind’ the permit.

The corporate practice of medicine bar essentially means that general corporations cannot engage in the practice of medicine. A professional medical corporation, however, may do so. Courts have identified sound public policy reasons for the bar: 1) Avoidance of divided loyalty to the patient and a profit motive, and 2) Avoidance of a lay person directing the actions of medical professional. From a real world perspective, the bar means that a general corporation cannot employ physicians, so if a medical spa or medi-spa is owned and operated by a general corporation and that corporation employs one or more physicians, then the law has been violated. The same analysis would hold if a physician is somehow supervised by an allied health provider,
as such a person is still an unlicensed person for the purpose of the corporate practice prohibition.

3. Does the Board have the power to adopt regulations regarding the specialty of physicians who supervise other licensed health care personnel? For example, could the Board require a physician to be Board certified in a certain field as a condition of supervising a licensed health care provider? Can there be a regulatory supervision ratio?

   A. Yes and No.

   At the most recent Committee meeting, there was considerable discussion regarding the applicable statutes and regulations regarding physician supervision of other licensed healthcare practitioners and the delegation of certain medical procedures and functions to those practitioners. The discussion also touched upon the Board’s power to potentially restrict or limit a physician’s authority to delegate or supervise in certain areas.

   In keeping with the legal concept that any regulatory attempt to limit delegation or supervision must fit within existing statute, it is necessary to examine the scope of existing law. Section 2018 does provide the Board with general regulatory authority, as follows:

   “The board may adopt, amend, or repeal, in accordance with the provisions of the Administrative Procedure Act, those regulations as may be necessary to enable it to carry into effect the provisions of law relating to the practice of medicine.”

   a. Physician Assistants

   Section 3516 of the Code prohibits a physician and surgeon from supervising more than four physician assistants at any one time. This same section of law provides that the Board may restrict a physician and surgeon’s ability to supervise specific types of physician assistants, including those physician assistants outside of the field of specialty of the physician and surgeon.

   Pursuant to section 3516, the Physician Assistant Committee (PAC) promulgated Section 1399.545 of title 16 of the California Code of Regulations, which provides as follows:

   “Bb) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.”

   With regard to the adequacy of physician supervision, Section 1399.545 also provides:

   “(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

   [Further details on guidelines for adequate supervision]
(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;
(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;
(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 10% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;
(4) Other mechanisms approved in advance by the committee.” (Emphasis added.)

The above regulations make specific the provisions of law regarding the supervision of physician assistants. Subdivision (e) of section 1399.545 does make it clear that a physician is not required to examine a patient prior to the patient receiving properly delegated medical services from the physician assistant since it provides other alternatives for compliance.

b. Licensed Midwives

Another example of a statutory scheme that limits a physician’s ability to supervise allied health personnel is the Licensed Midwifery Practice Act. Section 2507 of the Code provides in pertinent part:

“(a) The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn.
(b) As used in this article, the practice of midwifery constitutes the furthering or undertaking by any licensed midwife, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician and surgeon immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.
(c) As used in this article, "supervision" shall not be construed to require the physical presence of the supervising physician and surgeon.

(d) The ratio of licensed midwives to supervising physicians and surgeons shall not be greater than four individual licensed midwives to one individual supervising physician and surgeon.

(e) A midwife is not authorized to practice medicine and surgery by this article.

(f) The board shall, not later than July 1, 2003, adopt in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery. (Emphasis added.)

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Section 2507 sets a statutory limitation on which physicians can supervise a licensed midwife. The Committee should recognize that despite the statutory obligation in subdivision (f), the Board has been unable to adopt regulations that specify the appropriate level of supervision despite several attempts over a number of years. Of course, any regulation relating to the physician supervision of a midwife would be adopted pursuant to the specific authority granted above.

c. Nurse Practitioners

The Committee also inquired about the issue of nurse practitioners and physician supervision. With regard to nurse practitioners and the ordering or furnishing of drugs and devices, Section 2836.1 of the Code provides:

"Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:

(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what

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3 Section 2836.1 is outside of the Medical Practice Act.
circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.

(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.

(f) (1) Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.

(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

Current law, not regulation, establishes a supervision ratio requirement for nurse practitioners.

d. Polysomnographic Registrants

The California Legislature has recently enacted legislation regarding the practice of polysomnography and the registration of polysomnographic technicians, technologists and trainees. Section 3575 of the Code provides in pertinent part:

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"(e) Within one year after the effective date of this chapter, the board shall adopt regulations that establish the means and circumstances in which a licensed physician and surgeon may employ polysomnographic technicians and polysomnographic trainees. The board
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may also adopt regulations specifying the scope of services that may be provided by a polysomnographic technician or polysomnographic trainee. Any regulation adopted pursuant to this section may specify the level of supervision that polysomnographic technicians and trainees are required to have when working under the supervision of a certified polysomnographic technologist or licensed health care professional.” (Emphasis added.)

* * *

Given this statutory framework, the Board is proposing regulations that will establish a physician-to-registrant supervision ratio as well as require a physician to meet certain training or experience standards as a condition of supervising polysomnographic registrants. These regulations will be analogous to the statutory supervision provisions regarding midwives.

e. Section 2023.5

The Legislature has directed the Board to study the issues and concerns surrounding the use of lasers and intense pulse light devices with the enactment of section 2023.5 of the Code. Specifically, section 2023.5 of the Code provides:

“(a) The board, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, shall review issues and problems surrounding the use of laser or intense light pulse devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants. The review shall include, but need not be limited to, all of the following:

(1) The appropriate level of physician supervision needed.
(2) The appropriate level of training to ensure competency.
(3) Guidelines for standardized procedures and protocols that address, at a minimum, all of the following:
   (A) Patient selection.
   (B) Patient education, instruction, and informed consent.
   (C) Use of topical agents.
   (D) Procedures to be followed in the event of complications or side effects from the treatment.
   (E) Procedures governing emergency and urgent care situations.

(b) On or before January 1, 2009, the board and the Board of Registered Nursing shall promulgate regulations to implement changes determined to be necessary with regard to the use of laser or intense pulse light devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants.
This section gives the Board to authority adopt regulations in a narrow area: elective cosmetic procedures involving the use of laser or intense pulse light devices. The Board has not promulgated regulations in this area. However, it is important to note that the Board could not adopt regulations as to the scope of practice of registered nurses, as that is the responsibility of the Board of Registered Nursing. (See § 2725, subd. (e).)

4. Are the provisions of section 2242 of the Code applicable to this discussion as it pertains to elective cosmetic procedures?

Section 2242 of the Code provides:

“(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.
(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:
(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.
(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:
   (A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.
   (B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.
(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.”

By its own terms, this section does not apply to the prescribing or use of devices by a physician. As set forth above, physician assistants and nurse practitioners may order drugs or devices for patients under certain circumstances.
As Committee members know, the Board is responsible for disciplining physicians. The Board may bring an accusation against a physician for incompetence, gross negligence, repeated negligent actions or generalized unprofessional conduct. To bring such an action, the Board must first establish the standard of care, and expert testimony is required to do that.

CONCLUSION

In those areas where the Legislature has spoken on the issues of physician delegation and supervision, the Board has a clearer path toward the adoption of regulations that set parameters for physician supervision of allied health care providers. In areas where the Legislature has not so opined, the path is not so clear. Committee members should be aware that whenever the Board exercises its regulatory function, public protection is paramount. (See § 2001.1.)

As mentioned earlier, a regulation must meet several standards to be valid, and one of those standards is necessity. In other words, the Board would have to demonstrate by substantial evidence why the regulation is necessary, and from the Board’s perspective, the objective would be to explain how the proposed regulation furthers public protection. The Board would have to explain what problem it is trying to solve and why it chose this particular method of solving it.

For example, if a proposed regulation were to state that only specialty board certified physicians could supervise licensed healthcare practitioners performing medical services in that specialty, the Board may encounter difficulty because 1) the Board does not issue specialty licenses and 2) it may be unreasonable to presume that a physician who has worked in a particular area of practice but for whatever reason is not board certified does not have necessary knowledge or expertise to supervise the safe provision of services. Other generalized attempts to limit physician supervision will be difficult as well in the absence of a specific statutory obligation to set standards for supervision.

If the Committee believes that additional regulations are necessary to protect the public, it may wish to explore utilizing the authority granted in section 2023.5 to propose regulations specific to the use of lasers and intense pulse light devices to the Board. However, the Committee may wish to consider the implementation of other mechanisms to protect the public, including but not limited to public awareness measures.
GENERAL INFORMATION: NURSE PRACTITIONER PRACTICE

Scope of Practice
The nurse practitioner (NP) is a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program that conforms to Board standards as specified in California Code of Regulations, CCR, 1484 Standards of Education.

Primary Health Care
Primary health care is defined as, that which occurs when a consumer makes contact with a health care provider, who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease CCR 1480 (b). This means that, in some cases, the NP will be the only health professional to see the patient and, in the process, will employ a combination of nursing and medical functions approved by standardized procedures.

Clinically Competent
Clinically competent means that one possess and exercises the degree of learning, skill, care ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice (CCR 1480 c).

Legal Authority for Practice
The NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures for authorization to perform overlapping medical functions (CCR Section 1485). Section 2725 of the Nursing Practice Act (NPA) provides authority for nursing functions that are also essential to providing primary health care which do not require standardized procedures. Examples include physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, and withdrawal of blood, as well as authority to initiate emergency procedures.

Nurse practitioners frequently ask if they really need standardized procedures. The answer is that they do when performing overlapping medical functions. Standardized procedures are the legal authority to exceed the usual scope of RN practice. Without standardized procedures the NP is legally very vulnerable, regardless of having been certified as a RN, who has acquired additional skills as a certified nurse practitioner.

Certification
Registered nurses who have been certified as NPs by the California Board of Registered Nursing may use the title nurse practitioner and place the letters “R.N., N.P.” after his/her name alone or in combination with other letters or words identifying categories of specialization, including but not limited to the following: adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner. (CCR 1481)
On and after January 1, 2008, an applicant will be required for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master’s degree in nursing, a master’s degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. (Business and Professions Code 2835.5)

Furnishing Drugs and Devices
BPC Code Section 2836.1 authorizes NPs to obtain and utilize a “furnishing number” to furnish drugs and devices. Furnishing or ordering drugs and devices by the nurse practitioner is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure. Furnishing is carried out according to a standardized procedure and a formulary may be incorporated. All nurse practitioners who are authorized pursuant to Section 2831.1 to furnish or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

BPC 2836.1 was amended changing furnishing to mean “order” for a controlled substance, and can be considered the same as an “order” initiated by the physician. This law requires the NP who has a furnishing number to obtain a DEA number to “order” controlled substances, Schedule II, III, IV, V. (AB 1545 Correa) stats 1999 ch 914 and (SB 816 Escutia) stats 1999 ch 749.

Furnishing Controlled Substances:
The furnishing or ordering of drugs and devices occurs under physician and surgeon supervision. B&P Code Section 2836.1 extends the NP, who is registered with the United States Drug Enforcement Administration, the furnishing authority or “ordering” to include Schedule II through V Controlled Substances under the Uniform Controlled Substance Act (AB 1196 Montanez) Stats2004 ch 205 § (AB 2560) There are specified educational requirements that must be met by the furnishing NP who wishes to “order” Schedule II Controlled Substances.

Drugs and/or devices furnished or “ordered” by a NP may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 commencing with Section 11000) of the Health and Safety Code and shall be further limited to those drugs agreed upon by the NP and physician and specified in the standardized procedure.

When Schedule II or III controlled substances, as defined in Section 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a NP, the controlled substance shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. The provision for furnishing Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is to be furnished. A copy of the section for the NP’s standardized procedure relating to controlled substances shall be provided upon request to any licensed pharmacist who dispenses drugs or devices when there is uncertainty about the furnishing transmittal order.

The nurse practitioner with an active furnishing number, who is authorized by standardized procedure or protocols to furnish must submit to the BRN an approved course that includes Schedule II Controlled Substances content as a part of the NP educational program or a continuing educational course with required content on Schedule II Controlled substance. The proof of a Schedule II course
received by the BRN will be noticed on the board’s website, www.rn.ca.gov, in the NPF verification section.

A prescription pad may be used as transmittal order forms as long as they contain the furnisher’s name and furnishing number. Pharmacy law requires the nurse practitioner name on the drug and/or device container label. The name of the supervising physician is no longer required on the drug/device container label as pharmacy law was amended BPC 1470 (f) (AB 2660 Leno) stats 2004 ch 191. The nurse practitioner DEA number is required for controlled substances. Therefore, inclusion of this information on the transmittal order form will facilitate dispensing of the drug and/or device by the pharmacist.

Dispensing Medication
Business and Professions Code Section 2725.1 allows registered nurses to dispense (hand to a patient) medication except controlled substances upon the valid order of a physician in primary, community, and free clinic. Business and Professions Code Section 2725.1 was amended to extend to the furnishing nurse practitioner authority to dispense drugs, including controlled substances, pursuant to standardized procedures or protocols in primary, community, and free clinics. (AB 1545 Correa) stats 1999 ch 914)

Effective January 1, 2003, B&P Code Section 2836.1 Furnishing is amended to allow NPs to use their furnishing authority in solo practice per Senate Bill 933 (Figueroa) Chapter 764 signed by Governor Gray Davis on September 20, 2002.

Sign for the Request and Receipt of Pharmaceutical Samples and Devices.
Certified furnishing nurse practitioners are authorized to sign for the request and receipt of complimentary samples of dangerous drugs and devices identified in their standardized procedures or protocols that have been approved by the physician. (SB 1558 Figueroa stats 2002 ch 263) to take effect immediately. This new law amends B&P Code Section 4061 of the Pharmacy law to allow CNMs, NPs, and PAs to request and sign for complimentary samples of medication and devices.

Treating STDs
Amended into Section 120582 of the Health and Safety Code effective January 1, 2007:
(a) Not withstanding any other provision of law, a physician and surgeon who diagnoses a sexually transmitted chlamydia, gonorhea, or other sexually transmitted infection, as determined by the Department of Health Services, in an individual patient may prescribe, dispense, furnish, or otherwise provide a prescription antibiotic drugs to the patients sexual partner or partners without examination of that patient’s partners.
(b) Not withstanding any other provision a nurse practitioner practicing pursuant to BPC Section 2836.1; a certified nurse-midwife practicing pursuant to BPC Section 2746.51; and a physician assistant pursuant to BPC 3502.1 may dispense, furnish, or otherwise provide a prescription antibiotic drug to the sexual partner or partners of a patient with a diagnosed sexually transmitted Chlamydia, gonorhea, or other sexually transmitted infection, as determined by the Department of Health Services without examination of the patient’s sexual partners. (AB 2280 Leno stats 2006 ch ) (AB 648 Ortiz stats 2001 ch 835)

Workers’ Compensation Reports
Section 3209.10 added to the labor code gives nurse practitioners the ability to cosign Doctor’s First Report of Occupational Injury or illness for a worker’s compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized
procedure or protocols. The treating physician is required to sign the report and to make a
determination of any temporary disability. (AB 2919 Ridley-Thomas stats 2005 extends the operation
of this provision indefinitely-AB 1194 Correa stats 2001 ch 229 effective 2001)

Veterans with Disabilities Parking Placards:
Section 5007, 9105, 22511.55 of the Vehicle Code is amended to include nurse practitioners, nurse
midwives and physician assistants as authorized health care professionals that can sign the certificate
substantiating the applicant’s disability for the placard. (AB 2120 Lui stats 2007 ch 116)

Existing law authorizes the Department of Motor Vehicles to issue placards to persons with disabilities
and veteran with disabilities and temporary distinguishing placards to temporary disabled persons, to
be used for parking purposes. Prior to issuing the parking placard or temporary placard, the
Department of Motor Vehicles requires the submission of a certificate, signed by an authorized health
care professional providing a full description substantiating the applicant’s disability, unless the
disability is readily observable and uncontested. Under existing law, the authorized health care
professional that signs the certificate is required to retain information sufficient to substantiate the
certificate, and make the information available to certain entities request of the department.

Medical Examination School Bus Drivers
Vehicle Code Section 12517.2 (a) is amended relating to schoolbus drivers driver medical examination
to Applicants for an original or renewal certificate to drive a schoolbus, school pupil activity bus,
youthbus, general public paratransit vehicle, or farm labor vehicle shall submit a report of medical
examination of the applicant given not more than two years prior to the date of the application by a
physician licensed to practice medicine, a licensed advanced practice nurse qualified to perform a
medical examination, or a licensed physician assistant. The report shall be on a form approved by the
department, the Federal Highway Administration, or the Federal Aviation Administration.

Schoolbus drivers, within the same month or reaching 65 years of age and each 12th month thereafter,
shall undergo a medical examination, pursuant to Section 12804.9, shall submit a report of the medical
examination on a form specified in subsection (a) (AB 139 Bass stats 2007, ch 158)

Informing patient: Positive and Negative aspects of Blood Transfusions
Section 1645 of the Health and Safety Code is amended to authorize the nurse practitioner and the
nurse-midwife who is authorized to give blood may now provide the patient with information by
means of a standardized written summary as developed or revised by the State Department of Public
Health about the positive and negative aspects of receiving autologous blood and direct and
nondirected homologous blood to volunteers. (SB 102 Migden stat 2007 ch 88)

Existing law requires, whenever there is reasonable possibility, as determined by a physician, that a
blood transfusion may be necessary as a result of medical procedures, that the physician, by means of a
standardized written summary that is published by the Medical Board and now by the Department of
Public Health and distributed upon request, inform the patient of the positive and negative aspects of
receiving autologous blood and directed and non directed homologous blood from volunteers.

Medi-Cal Billing: Nurse Practitioner Nationally Certified in a Specialty
Section 14132. 41 of the Welfare and Institutions Code is amended services provided by a certified nurse
practitioner shall be covered under this chapter to the extent authorized by federal law, and subject to
utilization controls. The department shall permit a (nationally) certified nurse practitioner to bill Medi-
Cal independently for his or her services. If a certified (nationally) nurse practitioner chooses to bill
Medi-Cal independently for his or her service, the department shall make payment directly to the

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certified (nationally) nurse practitioner. For the purposes of this section, “certified” means nationally board certified in a recognized specialty.

Supervision
Supervision of the NP performing an overlapping medical function is addressed in the standardized procedure and may vary from one procedure to another depending upon the judgment of those developing the standardized procedure. As an example, in one women’s clinic the supervision requirement for performing a cervical biopsy was that a physician must be physically present in the facility, immediately available in case of emergency. For all other standardized procedure functions, the supervision requirement was for a clinic physician to be available by phone.

The furnishing or ordering of drugs and devices by nurse practitioners occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time the patient is being examined by the nurse practitioner. For furnishing purposes, the physician may supervise a maximum of no more than four (4) NPs at one time. (BPC 2836.1)

Supervision of Medical Assistants
Nurse Practitioners and Certified Nurse-Midwives may supervise Medical Assistants in “community clinics” or “free clinics” in accord with approved standardized procedures and in accord with those supportive services the Medical Assistant is authorized to perform (Business and Professions Code, Section 2069(a)(1); and Health and Safety Code, Section 1204(a) & (b).

Citation and Fine
NPs, like all registered nurses, are subject to citation and fine for violation of the NPA. Citation and fines are a form of disciplinary action against the RN license and/or certificate. Examples of violations which have resulted in citation and fine are using the title “nurse practitioner” without being certified as a NP by the California BRN and failing to have standardized procedures when performing overlapping medical functions. NPs are encouraged to comply with all sections of the NPA to avoid discipline.

References
B&P Code, Section 2725 RN Scope of Practice, Section 2834 Nurse Practitioner, California Code of Regulation Section 1435 Citations and Fines, Section 1470 Standardized Procedure Guidelines, Section 1480 Standards for Nurse Practitioners.

BRN Offices
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For more information, please visit the BRN’s Web site at www.rn.ca.gov
Delegation of Services Agreements – Change in Regulations

Recently, Title 16, Division 13.8, Article 4, section 1399.540 has been amended to include several requirements for the delegation of medical services to a physician assistant. There are four specific changes with this amendment:

Background:
The Delegation of Services Agreement (DSA) is a document used by supervising physicians and physician assistants to meet requirements of Section 1399.540. The DSA is the foundation of the relationship between a supervising physician and the physician assistant, and specifies the names of the supervising physicians and what types of medical services the physician assistant is allowed to perform, how they are performed, how the patient charts will be reviewed and countersigned, and what type of medications the physician assistant will transmit on behalf of the supervising physician.

Regulatory Requirements:

1) A physician assistant may provide medical services, which are delegated in writing by a supervising physician who is responsible for patients, cared for by the physician assistant. The physician assistant may only provide services which he or she is competent to perform, which are consistent with their education, training and experience, and which are delegated by the supervising physician.

2) The delegation of services agreement is the name of the document, which delegates the medical services. More than one supervising physician may sign the delegation of services agreement only if each supervising physician has delegated the same medical services. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

3) The Physician Assistant Committee or their representative may require proof or demonstration of competence from any physician assistant for any medical services performed.

4) If a physician assistant determines a task, procedure or diagnostic problem exceeds his or her level of competence, and then the physician assistant shall either consult with a physician or refer such cases to a physician.

Question: What if a physician assistant works for more than one supervising physician at a hospital or clinic? Do we need to have separate DSAs for each supervising physician?

Answer: The PAC has had questions regarding how the DSA would be written if a physician assistant works for more than one supervising physician at a hospital or clinic. If the duties and medical services performed are consistent with each supervising physician, then one DSA can be written to include several supervising physicians. Each supervising physician must sign and date the DSA, along with the signature of the physician assistant.
**Question:** What if a physician assistant works for one supervising physician who is an ob-gyn, and also works for an ortho supervising physician, and both are at the same clinic or hospital?

**Answer:** If the duties and medical services provided by the physician assistant differ from one supervising physician to another, then it is recommended that a separate DSA be written for each supervising physician. However, one DSA could be used, but it would need to be separated with which duties are allowed under each supervising physician. Again, signatures and dates from all parties must be included on the DSA.

**Question:** What if the physician assistant works at several different clinics – can one DSA be written?

**Answer:** A separate DSA should be made for each hospital or clinic, regardless of how many supervising physicians the physician assistant works with.

Alternatively, a physician assistant may have a DSA that specifies what services can be provided at a specific site.

**Question:** How long should I retain my DSA?

**Answer:** You should retain the DSA as long as it is valid. Additionally, it is recommended that you keep a copy of your DSA for at least one to three years after it is no longer the current DSA in case you need to reference the document. However, there is no legal requirement to retain the DSA once it is no longer valid and current.
Title 16, Section 1399.540 of the Physician Assistant Regulations states, in part, "A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant. b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement."

The following two sample documents are attached to assist you with meeting this legal requirement:

- Delegation of Services Agreement (DSA) Between Supervising Physician and Physician Assistant; and,
- Supervising Physician’s Responsibility for Supervision of Physician Assistant Agreement.

These are sample documents. They are for your convenience, information, and use. Please feel free to duplicate or modify them as appropriate and consistent with law.

If you choose not to use the sample documents, please be aware that you are still required by law to execute a DSA with your supervising physician. The DSA must be signed and dated by you and your supervising physician. The original or a copy of this document should be maintained at all practice sites where the physician assistant practices, and should be readily accessible. It is recommended that you retain prior DSAs for one to three years after the DSA is no longer current or valid.

While every practicing physician assistant is required to have a DSA, you are not required to submit it to the Physician Assistant Committee. If requested, you must make a copy of your DSA available to any authorized agent of the Medical Board of California, the Osteopathic Medical Board of California, or the Physician Assistant Committee who may request it.

Failure to have a current DSA constitutes a violation of the Physician Assistant Regulations and is grounds for disciplinary action against a physician assistant's license. In addition, failure by the physician assistant and supervising physician to comply with the supervision requirements specified in the Physician Assistant Regulations and in the Delegation of Services Agreement is ground for disciplinary action.

THE ATTACHED DOCUMENTS DO NOT NEED TO BE RETURNED TO THE PHYSICIAN ASSISTANT COMMITTEE
SAMPLE
DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN
AND PHYSICIAN ASSISTANT (Title 16, CCR, Section 1399.540)

PHYSICIAN ASSISTANT

(Name)

Physician assistant, graduated from the ________________________________ physician assistant training program on __________________________.

(Name of PA Training Program) (Date)

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California (e.g., Physician Assistant National Certifying Examination or a specialty examination given by the State of California) on __________________________.

(Date)

He/she was first granted licensure by the Physician Assistant Committee on __________________________, which expires on __________________________, unless renewed. (Date)

SUPERVISION REQUIRED. The physician assistant named above (hereinafter referred to as PA) will be supervised in accordance with the written supervisor guidelines required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations. The written supervisor guidelines are incorporated with the attached document entitled, "Supervising Physician's Responsibility for Supervision of Physician Assistants."

AUTHORIZED SERVICES. The PA is authorized by the physician whose name and signature appear below to perform all the tasks set forth in subsections (a), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, when acting under the supervision of the herein named physician. (In lieu of listing specific lab procedures, etc. the PA and supervising physician may state as follows: "Those procedures specified in the practice protocols or which the supervising physician specifically authorizes.")

The PA is authorized to perform the following laboratory and screening procedures:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

The PA is authorized to assist in the performance of the following laboratory and screening procedures:

________________________________________________________________________

________________________________________________________________________

The PA is authorized to perform the following therapeutic procedures:

________________________________________________________________________

________________________________________________________________________

The PA is authorized to assist in the performance of the following therapeutic procedures:

________________________________________________________________________

________________________________________________________________________

The PA is authorized to function as my agent per bylaws and/or rules and regulations of (name of hospital):

________________________________________________________________________

________________________________________________________________________

a) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V without advance approval (circle authorized Schedule(s)). The PA has taken and passed the drug course approved by the PAC on ________________ (attach certificate). DEA #: ________________________ Date

or

b) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V with advance patient specific approval (circle authorized Schedule(s)). DEA #: ________________________
CONSULTATION REQUIREMENTS. The PA is required to always and immediately seek consultation on the following types of patients and situations (e.g., patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any conditions which the physician assistant feels exceeds his/her ability to manage, etc.)

(Medical Devices and Physician's Prescriptions. The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription drug order, the supervising physician's prescription in accordance with Section 3502.1 of the Business and Professions Code.

The supervising physician authorizes the delegation and use of the drug order form under the established practice protocols and drug formulary. YES NO

The PA may also enter a drug order on the medical record of a patient at ___________________________ (Name of Institution) in accordance with the Physician Assistant Regulations and other applicable laws and regulations.

Any medication handed to a patient by the PA shall be authorized by the supervising physician's prescription and be prepackaged and labeled in accordance with Sections 4076 of the Business and Professions Code.

PRACTICE SITE. All approved tasks may be performed for care of patients in this office or clinic located at ___________________________ (Address / City) and, in ___________________________ hospital(s) and ___________________________ (Name of Facility) skilled nursing facility (facilities) for care of patients admitted to those institutions by physician(s) ___________________________ (Name/s).

EMERGENCY TRANSPORT AND BACKUP. In a medical emergency, telephone the 911 operator to summon an ambulance.

The ___________________________ emergency room at ___________________________ (Name of Hospital) (Phone Number) is to be notified that a patient with an emergency problem is being transported to them for immediate admission. Give the name of the admitting physician. Tell the ambulance crew where to take the patient and brief them on known and suspected health condition of the patient.

Notify ___________________________ (Name of Physician) (Phone Number/s)) immediately (or within ________ minutes).

PHYSICIAN ASSISTANT DECLARATION

My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

____________________________
Date

____________________________
Physician's Signature (Required)

____________________________
Physician's Printed Name

____________________________
Date

____________________________
Physician Assistant's Signature (Required)

____________________________
Physician Assistant's Printed Name

SAMPLE ONLY
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SUPERVISING PHYSICIAN'S RESPONSIBILITY FOR SUPERVISION OF PHYSICIAN ASSISTANT

SUPERVISOR ____________________________________________, M.D./D.O. is licensed to practice in California as a physician and surgeon with medical license number ___________________. Hereinafter, the above named physician shall be referred to as the supervising physician.

SUPERVISION REQUIRED. The physician assistant (PA) named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these guidelines, set forth as required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations, which have been read by the physician whose signature appears below.

The physician shall review, countersign, and date within seven (7) days the medical record of any patient cared for by the physician assistant for whom the physician's prescription for Schedule II medications was transmitted or carried out.

REPORTING OF PHYSICIAN ASSISTANT SUPERVISION. Each time the physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When the physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

MEDICAL RECORD REVIEW. One or more of the following mechanisms, as indicated below, by a check mark (x), shall be utilized by the supervising physician to partially fulfill his/her obligation to adequately supervise the actions of the physician assistant named _____________________________.

_____ Examination of the patient by a supervising physician the same day as care is given by the PA.

_____ The supervising physician shall review, audit, and countersign every medical record written by the PA within _________ days of the encounter. (Number of Days May Not Exceed 30 Days)

_____ The physician shall audit the medical records of at least 5% of patients seen by the PA under any protocols which shall be adopted by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

_____ Other mechanisms approved in advance by the Physician Assistant Committee may be used. Written documentation of those mechanisms is located at _______________________________. (Give Location)

INTERIM APPROVAL. For physician assistants operating under interim approval, the supervising physician shall review, sign, and date the medical records of all patients cared for by the physician assistant within seven (7) days if the physician was on the premises when the physician assistant diagnosed or treated the patient. If the physician was not on the premises at that time, he or she shall review, sign, and date such medical records within 48 hours of the time the medical services were provided.

BACK UP PROCEDURES: In the event this supervising physician is not available when needed, the following physician(s) has (have) agreed to be a consultant(s) and/or to receive referrals:

__________________________
(Printed Name and Specialty) Phone: __________________________

__________________________
(Printed Name and Specialty) Phone: __________________________

PROTOCOLS NOTE: This document does not meet the regulation requirement to serve as a protocol. Protocols, if adopted by the supervising physician, must fully comply with the requirements authorized in Section 3502 (c) (1) of the Business and Professions Code.

__________________________
Date

__________________________
Physician's Signature

THIS DOCUMENT IS NOT TO BE RETURNED TO THE PAC
SAMPLE ONLY
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PHYSICIAN ASSISTANT SCOPE OF PRACTICE

Due to the increasing complexity and proliferation of medical services available today, the Physician Assistant Committee (PAC) has received a number of inquiries regarding physician assistant (PA) scope of practice in the State of California. All PAs, physician supervisors, and interested others may consequently be advised of the following:

A physician assistant may only provide those medical services which:
(1) he or she is competent to perform, as determined by the supervising physician,
(2) are consistent with his/her education, training, and experience, and
(3) are delegated in writing by the supervising physician responsible for the patients cared for by the PA.

In accordance with these criteria and other provisions set forth in the PA law and regulations, and not withstanding any other provision of law, a PA may work in any setting, and may provide any medical service with the exception of certain ophthalmological and dental procedures listed in law [Business and Professions Code, Section 3502(c)]. Please note that Section 3502.1 of the Business and Professions Code allows a PA to issue a written drug order based on the supervising physician’s prescription order.

Specific examples of some of the medical services performable by a PA are listed in regulation (Title 16 California Code of Regulations Section 1399.541). However, should additional questions arise concerning PA scope of practice, the Physician Assistant Committee may be reached at (916) 561-8780 or paccommittee@mbc.ca.gov to address inquiries of this nature.

Note: This document does not purport to be an exhaustive analysis of laws relating to physician assistants. This is not a declaratory opinion of the Physician Assistant Committee.

Rev 03/08
SUPERVISION of PHYSICIAN ASSISTANTS

Changes to the law have made it easier for a physician to work with a physician assistant (PA). Medical Board approval to supervise a PA is no longer necessary and some of the duties and responsibilities of supervising a PA have changed.

Supervisory Requirements
Listed below are some of the PA supervisory requirements:

- According to California law, all care provided to a patient by a physician assistant is the ultimate responsibility of the supervising physician.
- Current law allows a physician to supervise no more than four physician assistants (PAs) at any moment in time.
- According to regulations, the physician must be in the same facility with the PA or be immediately available by electronic communications.
- Before authorizing a PA to perform any medical procedure, the physician is responsible for evaluating the PA's education, experience, knowledge, and ability to perform the procedure safely and competently. In addition, the physician should verify that a PA has a current California license issued by the Physician Assistant Committee (PAC) (PAC website: www.pac.ca.gov)
- PAs may not own a medical practice. (Please see Section 13400 and following of the Corporations Code.)
- PAs may not hire their supervisors. PAs are dependent practitioners who act as agents on behalf of a supervising physician.

Physicians who plan to supervise PAs should carefully review Business and Professions Code section 3502 and 3502.1 and Section 1399.545 of Title 16 of the California Code of Regulations for a complete listing of supervision requirements available on the PAC website www.pac.ca.gov.

There are four methods for providing supervision of a physician assistant.

1. The physician sees the patients the same day that they are treated by the PA.
2. The physician reviews, signs and dates the medical record of every patient treated by the physician assistant within thirty days of the treatment.
3. The physician adopts written protocols, which specifically guide the actions of the PA. The physician must select, review, countersign and date a sample, consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.
4. Or, in special circumstances, the physician provides supervision through additional methods approved in advance by the PAC.

To fulfill the required supervisor obligation, the physician must utilize one or a combination of the four authorized supervision methods.

Delegation of Services Agreement
For the mutual benefit and protection of patients, physicians and their PAs, the PA regulations require the physician to delegate in writing, for each supervised physician assistant, those medical services which the PA may provide. That document is often referred to as a Delegation of Services Agreement. A sample is available on the PAC website www.pac.ca.gov. Medical tasks, which are delegated by a supervising physician, may only be those that are usual and customary to the physician's practice.

Drug Orders
- Pharmacy Law (Business and Professions Code Section 4000 et seq.) authorizes licensed pharmacists to dispense drugs or devices based on a PA’s “drug order”. Current law also allow PAs to obtain their own DEA numbers for use when writing prescription drug orders for controlled substances.
- Current law permits physician assistants to write and sign prescription drug orders when authorized to do so by their supervising physicians for Schedule II-V medication.
- A PA may only administer, provide, or transmit a drug order for Schedule II through Schedule V controlled substances with the advance approval by a supervising physician for a specific patient unless a physician assistant completes an approved education course in controlled substances, and if delegated by the supervising physician. If a physician assistant chooses not to take the educational course, the requirements for patient-specific authority remain unchanged. The Committee has proposed regulations to implement this provision. The proposed regulations can be found at www.pac.ca.gov. Please check our website for updates to this information.
- In order to ensure that a PA's actions involving the prescribing, administration or dispensing of drugs is in strict accordance with the directions of the physician, every time a PA administers or dispenses a drug or transmits a Schedule II drug order, the physician supervisor must sign and date the patient's medical record or drug chart within seven days.

All physician assistants and supervising physicians should familiarize themselves with all physician assistant laws and regulations to ensure they are in compliance with the physician assistant laws and regulations.

For physicians who are interested in utilizing physician assistants and would like to know more about the benefits and requirements of using physician assistants, several publications are available from the PAC, including:

Physician Assistant Laws and Regulations
Sample Delegation of Services Agreement
Drug Orders by Physician Assistants (information bulletin)
What is a PA? (Patient information brochure -English & Spanish)

To request publications or to verify physician assistant licensing information, contact:
Physician Assistant Committee
2005 Evergreen Street, Suite 1100
Sacramento, CA 95815
Telephone: (916) 561-8780 FAX: (916) 263-2671
Website: www.pac.ca.gov Email: pacommittee@mbc.ca.gov

This article has highlighted many of the key responsibilities a physician assumes when approved to utilize physician assistants. It does not cover all the requirements of law. This is not a declaratory opinion of the Physician Assistant Committee or the Medical Board of California.