STATE AND CONSUMER SERVICES AGENCY - *Department of Consumer Affairs* Edmund G. Brown Jr., *Governor*

# MEDICAL BOARD OF CALIFORNIA

**Executive Office**

## Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals

**October 20, 2010**

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

**MINUTES**

**Agenda Item 1: Call to order - Dr. Moran**
Dr. Moran called the meeting to order at approximately 11:00 a.m.

**Agenda Item 2: Roll call**
Roll was taken and a quorum was present.

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

**Absent**
Suzanne Kilmer, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

**Staff of Committee:**
Candis Cohen

**Medical Board Staff:**
Kurt Heppler, Legal Counsel
Debbie Nelson, Research Analyst
Kevin Schunke, Manager, Licensing
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation

Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing
Barbara Yaroslavsky, Board President
Chris Valine, Public Information Analyst

**Audience**
Duane Bradley, Blue Shield of California
Julia Canzini, Blue Shield of California
Fred Cardinas, CA Assn of Nurse Anesthetists
Yvonne Choong, CA Medical Association
Bryce Docherty, CA Academy of Physician Assistants
Jana DuBois, CA Hospital Association
Erica Eisenlauer, DCA Legislation
Dean Grafilio, CA Medical Association
Christine R. Hall, Health Care Provider Counsel
Dorel Harms, CA Hospital Association
Paul Hegyi, CA Medical Association
Steve Kionus, Physician Assistant Committee
James Kojian, M.D.
Jake Laban, JLL Solutions, Inc.
Kathleen McCallum, NCANA
Tim Madden, CA Society of Plastic Surgeons
Miyo Minato, Board of Registered Nursing
Elberta Portman, Physician Assistant Committee
Rosielynn Pulmano, Senate B&P Committee
Veronica Ramirez, CA Medical Association
Tom Riley, CALDERM/CCG
Melanie Rowe, RN
Katherine Scholl, USD, CPIL
Rehan Sheikh, for Farzana Sheikh, M.D.
Shannon Smith-Crowley, American Congress of OB/GYNs
Jonathan Sykes, M.D.
Dean Vistnes, M.D.
Hermine Warren, FM, Inc.
Kristy Wiese, CA Association of Nurse Practitioners

**Agenda Item 3: Public comment on items not on the agenda**
There was no public comment.

**Agenda Item 4: Approval of Committee meeting minutes of June 23, 2010 – Dr. Moran**
A motion was made to approve the meeting minutes of June 23, 2010; the motion was seconded and carried.

**Agenda Item 5: Update of the status of SB 1150 (Negrete McLeod) and AB 2566 (Carter) – Ms. Simoes**

**SB 1150** (Negrete McLeod) is the bill that would have imposed various requirements relating to healthcare practitioner advertising, cosmetic surgery, outpatient settings and accreditation. The Medical Board took a support position on this bill. Unfortunately this bill did not make it out of Assembly Appropriations; it is no longer active.

**AB 2566** (Carter) is the bill that would have prohibited outpatient cosmetic surgery centers from violating the prohibition of the corporate practice of medicine. Would have also enhanced the penalties. The bill was supported by the Medical Board; however, it was vetoed by the Governor.

**Agenda Item 6: Legal staff review of 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**

Mr. Heppler provided a memo to address questions raised by the committee at the last meeting. Mr. Heppler referred to Dr. Moran's request that he talk about the medi spa issue. Dr. Moran asked Mr. Heppler to explain the difference between a general corporation and a professional medical corporation: who can be a director and who can be an officer? Mr. Heppler explained, in a professional medical corporation, a shareholder is limited to those persons holding licenses as enumerated in B&P Code section 2400. The majority of shares must be owned by the physician(s), and the number of allied health professionals holding shares cannot outnumber the physicians holding shares. Whereas, a general corporation cannot practice medicine and anyone can hold shares in the corporation.

Mr. Heppler noted if medi spas or any other business combination does practice in violation of the corporate practice of medicine, they are subject to discipline.

Dr. Moran noted the memo Mr. Heppler wrote has very valuable and informative.

<u>What is the practice of medicine?</u> Mr. Heppler stated this is answered in section 2051, which states what the physician and surgeon certificate authorizes the holder of said certificate to do. In 2052, it states what is not permitted if you do not hold a license. Sections 2053.5 and 2053.6 elaborate on those points.

<u>Is there a statutory or regulatory definition of a medical spa within the Medical Practice Act or its intended regulations?</u> Mr. Heppler stated his independent research indicates there is no definition of a medical spa. Mr. Heppler explained a fictitious name permit is required if the physician wants to practice under a name other than his licensed name. A corporation would have to be a professional medical corporation, as well. A fictitious name permit is not insulation against an improper corporation or general corporation. They are two different things.

Dr. Bruner stated the use of the word "medical" or "med spa" implies that the practice of medicine is going on. Dr. Bruner stated if one of those entities is actually practicing medicine without the term *medi* or *medical spa* then obviously they might be in violation of the code. Dr. Bruner asked Mr. Heppler to comment.

Mr. Heppler answered that the threshold question from the Medical Board's perspective would be what actually is going on within the confines of that space. Mr. Heppler noted he would place less of an emphasis on the name, and perhaps more emphasis on what task is actually being done or the services being provided at that site.

Ms. Scuri added the practice of medicine has two prongs; one is actually practicing medicine and the other is holding yourself out as able to practice medicine. So the name itself may be an issue if the entity is not authorized to practice medicine. Then there's the question of what are they doing?

Dr. Bruner stated if they are using the word *medical* or *medi*, it is pretty easy to connect the dots that the practice of medicine is going on in that particular entity.

Dr. Robbins asked if a doctor's name is visible, is that okay.

Mr. Heppler stated that if a doctor's name was present, there would be a greater representation that medical services are actually being provided.

The question was asked if the name *medi-spa* implies to the public it is medical.

Mr. Heppler thought the issue would be related to discipline as it would be holding yourself out as doing medical things, when you are not properly authorized to do so. To the extent that a physician's name is associated with this particular location might lead better credence to the fact that there are medical services going on.

Dr. Moran stated the setting is not quite as important as is who is doing what under what circumstances, and what the role of the physician is in that supervision.

Dr. Barnard asked if supervision by telemedicine is addressed in the memorandum.

Dr. Moran stated not specifically in this discussion today, but certainly by implication.

<u>Does the Medical Board have the power to adopt regulations regarding the specialty of physicians who supervise other licensed health care personnel?</u> Mr. Heppler stated he wanted to research past history and the current law. Mr. Heppler stated the question about whether the Board could adopt regulations is not so clear in the absence of specific statutory authority. However, the legislature has clearly said to the Medical Board, you can promulgate regulations to implement changes in regard to laser elective or intense pulse light for elective cosmetic procedures.

Dr. Moran asked about the appropriate prior examination and if that goes to both dangerous drugs and devices.

Mr. Heppler replied this speaks to dangerous drugs.

Dr. Robbins stated there is a question of actual supervision and how that is defined.

Dr. Moran replied they would see if there were any gray zones.

**Agenda Item 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**
Ms. Minato introduced herself and stated she has been with the nursing board for ten years and would answer questions about scope of practice for registered nurses.

Ms. Minato reported that during the 1973-74 legislative session, the legislature recognized nursing is a dynamic field and is continually evolving to include more sophisticated patient care activities. The intent was to amend B&P Code section 2725 to provide clear, legal authority for functions and procedures that have common acceptance and usage, and to recognize the existence of overlapping functions between registered nurses and medicine, allowing additional sharing of functions using standardized procedures in a health care work setting that provides for collaboration between physicians and registered nurses.

Ms. Minato explained section 2725 of the code specifically identifies the scope of registered nursing practice. It is the direct and indirect patient care services in the areas of safety, comfort, personal hygiene, and protection of patients that includes disease protection and restorative measures. There are also direct and indirect patient care services, which is the administration of medication and therapeutic actions that are ordered by licensed providers. These require a physician's order to carry out; however, how the order is carried out does not require a physician's supervision, as long as the nurse is competent to do so and is within his or her scope of practice. Observations and assessments are part of registered nursing functions and determining abnormal characteristics that the nurse would refer, report, take action, or implement standardized procedures. The registered nurses scope of practice cannot be expanded beyond what is allowed in B&P Code section 2725. Facilities may restrict practice within their own policies and procedures.

Ms. Minato addressed the question of standardized procedures and allowing a registered nurse, including nurse midwives and nurse practitioners, to furnish medications. Although this is considered outside the scope of registered nursing, it is allowed through collaborative agreements. When someone is diagnosing, prescribing, severing tissue, or performing surgery, diagnosing and treating a disease, injury, deformity, etc., this is considered medical practice and requires standardized procedures for the registered nurse to carry out these functions. Standardized procedure is what gives legal authority for registered nurses to practice and overlap into the scope of the practice of medicine. In the California Code of Regulations, standardized procedure function is defined. One of the requirements is that whenever a registered nurse or nurse practitioner is using standardized procedure functions, it must be done within an organized health care system, i.e., physician's office, clinic, public or community health services, or home health agency.

In order for a nurse practitioner to practice standardized procedures a written document must be developed which specifically identifies the training of the nurse practitioner, how often the nurse needs to review or receive additional training, as well as how he or she is going to be supervised by the supervising physician, i.e., whether the physician needs to actually be on site. The standardized procedure determines how the

nurse practitioner's scope of practice will take place, and is developed by the parties involved – the physician, the nurse, and the administrator of the facility.

There are four categories of advanced practice nurses: nurse midwife, nurse anesthetist, nurse practitioner, and clinical nurse specialist. These are registered nurses who possess additional skills of physical diagnosis, psycho social assessment, management of health illness needs, and are usually in primary care. For functions that overlap medical practice, such as diagnosing and prescribing treatments or medications, nurse practitioners adhere to standardized procedures. In January 2010 a new statute (B&P 2835.7) added authorization for nurse practitioners to order durable medical equipment, certify disability, approve, sign, and modify or add to a plan of treatment a plan of care for individuals receiving home health or personal care services. Nurse practitioners do not have prescriptive authority. They "furnish" medications to patients, but do not use the term "prescribe." Medications are furnished or ordered by nurse practitioners in accordance with standardized procedures protocol and must be consistent with the nurse practitioner's educational preparation, as well as clinical competency.

When a physician is supervising a nurse practitioner who is furnishing medications, a physician can only supervise four nurse practitioners at any one time. Nurse practitioners are now able to order drugs, including controlled substances, and there are specific requirements under which nurse practitioners may prescribe these medications, and there are guidelines as to how standardized procedures can be developed for nurse practitioners to be able to furnish these drugs. Ms. Minato stated she would not go into those specifics at this time. However, she did add that in order to prescribe, nurse practitioners must get a "furnishing number" from the Board of Registered Nursing and obtain their own DEA number.

Ms. Minato replied to questions:.
1) A registered nurse may not prescribe dangerous drugs; only a nurse practitioner may furnish dangerous drugs using standardized procedures guidelines;
2) A patient must be seen by the supervising physician prior to delegation of the treatment. A registered nurse implements orders given by the physician; therefore, the nurse practitioner cannot independently initiate a treatment plan; and
3) Nurse practitioners can delegate treatment to a registered nurse only if the nurse practitioner is writing the order based on the standardized procedure guidelines. She added the nurse must be competent to perform the function, and a physician has signed off on the standardized procedure guideline.

Dr. Moran asked if nurse practitioners can delegate treatment to a registered nurse if they do a prior exam, or does it have to be done by a physician?

Ms. Minato stated she believed nurse practitioners can write orders that are carried out by a registered nurse. A nurse practitioner's orders are taken as if being provided by the physician if they are based on standardized procedures guideline.

Dr. Moran asked if this was in statute that nurse practitioners can supervise registered nurses in this way.

Ms. Minato replied the law is not written in that way. She continued that they could supervise this way if there is a standardized procedures guideline in place, and if the registered nurse who is implementing that

standardized procedures function is competent to perform those functions, and if there is a physician who has signed off on that standardized procedure guideline.

Ms. Minato stated she is trying to separate registered nurse functioning vs. nurse practitioner functioning under standardized procedure guidelines. She stated if she were receiving an order without a physician ever seeing the patient, she would probably say no.

Dr. Bruner complimented Ms. Minato on her presentation. He asked if the scope of independent practice for a nurse practitioner can gradually evolve and increase when it is commonly accepted, and who decides when that happens.

Ms. Minato stated when it became common practice for registered nurses to be doing it, standardized procedures guidelines were stopped.

Dr. Bruner asked when a procedure should be considered as a common practice?

Ms. Minato answered they first do research as to what practices are being done by searching literature for published articles, as well as do a survey in their community as to how that community is practicing.

Dr. Bruner asked if there is common agreement between the nurses who are deciding this and the physicians who are overseeing it.

Ms. Minato stated they tell the practicing nurse to go through the inter discipline committee of their organization before changes to policies and procedures are made, and that is the way things have evolved over time.

Jonathan Sykes, President of the American Academy of Facial, Plastic, and Reconstructive Surgery commented that he is on the faculty at UC Davis and has been on their interdisciplinary practices board that decides on standardized procedures. Dr. Sykes explained how the protocols are set up through a committee of physicians, nurses, and nurse practitioners.

Ms. Minato stated there is no specific requirement that physicians be experts in the fields in which they are supervising, except in the practice of a certified nurse midwife. The Board strongly recommends nurse practitioners select an appropriate physician supervisor.

Ms. Warren, a member of the public, stated she is a certified nurse midwife and also has advanced practice status. She wanted to address supervising medical doctors offsite and introduce the validity of telemedical supervision and telemedical good faith exams. Ms. Warren reminded the Board there are four groups of advanced practice people, not only physician assistants and nurse practitioners. She believes the four disciplines also have the ability to have extended scope of practice and be able to handle the ability with protocols that are in place by the medical doctor, and she would like this to be considered.

Kathleen McCallum, representing the Northern California Esthetic Nurses Association, stated they are concerned with a discussion of potentially restricting what can be done without a physician being on site in

areas such as hospice, dialysis, intensive care units, and emergency rooms. She would like to see furnishing drugs to be kept in perspective; they are following physician orders, using standardized procedures, and are competently trained.

Dr. Kojianm, member of the public, commented on the verbiage "physician supervision." He asked if the Medical Board, in keeping with patient safety, had instituted any protocols in training nurses to assure competency, such that they could take a class. Dr. Kojian suggested instituting policies and procedures to maintain the competency of the injector.

Dr. Moran asked if the Board of Nursing has a position on whether a nurse practitioner can hire her own medical doctor supervisor.

Ms. Minato replied that a nurse practitioner cannot hire a medical doctor because he or she cannot have a medical practice.

Ms. Scuri asked if the Board of Registered Nursing has a position on whether a registered nurse, who is not an advanced practice nurse, can perform medical functions under standardized procedures.

Ms. Minato replied the statute allows for registered nurses to do so.

**B. Physician Assistant Committee, Steven Klompus, Chairperson of the Committee**
Steven Klompus, chairperson of the Physician Assistant Committee, stated he has been a physician assistant since 1975, and he practices occupational medicine. Mr. Klompus explained he was a corpsman in the military in 1966-1969 during the Vietnam era, and when he got out he was a Special Forces corpsman. Dr. Steed at Duke University in 1964 felt there were a lot of qualified medics coming out of the military that could not do anything legally legally because they were not a doctor or a nurse. Thus, the physician assistant concept was begun. The idea was to teamwork with physicians and to offer and provide care to underserved areas or areas where physicians were overworked.

A physician assistant may provide only medical services which the physician assistant is competent to perform, as determined by the supervising physician, are consistent with his or her education, training, and experience, and are delegated in writing in a document called the "Delegation of Services Agreement" between the physician and the physician assistant. Physician assistants are definitely dependent practitioners and work as a team with their supervising physicians.

According to Code Section 3503, a physician assistant may administer or provide medication to a patient or transmit orally or in writing on a patient's record or in a drug order. As a nurse's terminology is "furnishing" , the physician assistant's is "drug order". Physician assistants also do not have prescribing privileges. Physician assistants have a "drug order", which looks like a prescription. Physician assistants can write out, phone in, or dispense medicines in their practice. Physician assistants are dependent practitioners.

Under the delagatory agreement, the physician assistant may issue drug orders. The physician may limit that authority. The physician determines the parameters of what kind of drug orders the physician assistant can issue.

Physician assistants are teamed up with physicians. Working alone should not be confused with independent practice. The physician must be available by electronic means and must co-sign 5% of a physician assistant's charts. The supervising physician always has the continued responsibility for the patient.

A recent bill required the Physician Assistant Committee to approve a physician assistant to write an order for a scheduled drug. Now there is a class you take for eight hours. If a physician assistant takes and passes that class, then specific approval is not required for every patient. There is blanket authority to issue an order for scheduled drugs without that approval.

A physician assistant may only perform medical services that he or she is competent to perform, and which are consistent with the physician assistant's education, training, and experience, and which is also consistent with the supervising physician's specialty and usual or customary practice, even if they have prior experience in that specialty. They have to practice under the parameters of the supervision physician's specialty.

Because the physician assistant's practice is directed by the supervising physician, and the physician assistant acts as an agent for that supervising physician, the orders given and tasks performed by a physician assistant are considered the same as if they are given by a physician.

Dr. Bruner asked how a physician assistant recognizes the supervising physician has the skills and knowledge to supervise them.

Mr. Klompus responded the same way as the physician determines the physician assistant's education and training. If the physician assistant, as a professional, feels the physician is not qualified to be doing certain things in your practice or qualified to supervise you, then you should refrain from doing those procedures.

Dr. Bruner asked if the physician assistant's liability is involved in making this decision. If the physician turns out not to be well trained, how liable is the physician assistant?

Mr. Klompus replied their malpractice is covered as a blanket policy under the physician's. The physician assistant would probably be liable, but the physician is ultimately responsible for anything to do with the patient.

Dr. Bruner asked if there are ways to recognize areas of expertise within the physician assistant field, such as an expert in psychiatry or orthopedics. Do physician assistants have sub certifications?

Mr. Klompus answered, "No." Every physician assistant who graduates has to take a national certification exam, and it is in primary care. There are physician assistants who go on to specialize in orthopedics, plastic surgery, dermatology, etc., but there is no certification. Mr. Klompus also mentioned there are 143 physician assistant programs in the United States, nine of which are in California.

Ms. Grivett commented they are starting to award recognition in specialties, but it does not take the place of the recertification exam every six years or continuing education requirements. California does not have such specialties.

Ms. Minato clarified that registered nurses are not supervised by physician assistants. Physician assistants can give orders and registered nurses will follow those orders because they are the physician's orders. That is not the same as supervision.

Dr. Moran thanked the speakers and summarized that there are clear standardized procedures and protocols that nurses abide by. Nurse practitioners do have the authority to write drug orders and do the appropriate prior exam; registered nurses do not have this authority.

Dr. Moran commented that if there are any loopholes where patient safety is concerned, then perhaps this would be a good time to bring up what the committee would like to offer in order to increase patient safety. Is there an enforcement problem or do we need new regulations?

**Agenda Item 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?**

Dr. Moran asked the members of the committee to note the letter from the American Society of Dermatologic Surgery. The letter states they would like to support continued legislation to increase penalties where regulations are not being followed, and allow the Board to improve enforcement of existing laws. They want to expand Operation Safe Medicine, which did not get approval for continued support.

Dr. Moran asked if there are any more questions or suggestions from the public dealing with the role of physicians, nurses, physician assistants, or nurse practitioners.

Dr. Sykes, a member of the public, reported there is a loop hole that occurs between how training is described and what is actually performed. Dr. Sykes remarked he did not think anybody was supervising through telemedicine. He believes there is very poor to no supervision being done at a lot of the medical spas, even though a physician is receiving money. The bigger problem is how do we enforce the law? Unless we are going to enforce it, there is almost no reason to have regulations.

Ms. Warren, a member of the public, commented that everyone's main perspective is patient safety. She stated a weekend course is not enough; people need to be trained properly and have the ability to understand what is a complication before they get a complication.

Tom Riley, representing CalDerm, stated they were one of the sponsors of AB 2566. Many cases they provided to members were situations where a well-intentioned provider did not have a physician available to ask a question of or to come in. The American Society of Dermatologic Surgery recommends a physician's presence. They suggested that legal counsel develop recommendations for owners of medical spas to look at to know how they need to comply.

Dr. Moran entertained a motion that the Board consider in its outreach program, including a Newsletter article, informing physicians and the public of their responsibilities regarding the supervision and delegation to various allied health care providers. M/S/C

**Agenda Item 9. Future agenda items and meeting dates.**

It was suggested that the Committee look at the issue of supervision and if further clarification is needed; define what is a medical spa; look at ways to support and further enhance supervision; decide if further legislation needs to be supported; suggestions for a public relations effort to educate physicians of their responsibilities regarding supervision and educating the public about medical spas; and informed consent explaining the risks for medical spa procedures;

**Agenda Item 10. Adjournment**

The meeting was adjourned at 12:58 p.m.