Physicians and Surgeons--The Expanding Role of the Physician's Assistant

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The shortage of health care professionals in West Virginia today is a matter of grave concern, especially to inhabitants of rural areas where professional medical care is often nonexistent. Statistics are indicative of the problem, but do not reveal the entire picture. For example, in the United States today, there are approximately 171 physicians per 100,000 population.¹ In West Virginia, each 100,000 persons is served by only 111 physicians.² This figure alone is cause enough for concern, but the seriousness of the situation is more accurately indicated by the distribution of the physician population. West Virginia is primarily a rural state with a few large urban centers. Fully two-thirds of West Virginia’s licensed physicians reside in twelve counties.³ In contrast, Putnam County has a population of 27,625 and only three physicians; Tucker County has one physician for its 7447 residents.⁴

The hospital bed situation is of similar gravity. In Monongalia County, for example, there are a mere ninety-nine persons per hospital bed.⁵ The figure is 162 per bed in Kanawha County—still highly acceptable.⁶ However, Boone County, with a population of over 25,000, has one hospital bed for each 598 persons—more than a little crowded.⁷

It is difficult to arrive at any definite conclusion as to the reasons for the health manpower shortage in West Virginia. Economic reasons are perhaps the most obvious. Practice in many of

¹The research contained in this article was part of the material gathered pursuant to a study of health manpower law in West Virginia, funded by the West Virginia Regional Medical Program.


³Id.

⁴Berkeley, Cabell, Hancock, Harrison, Kanawha, Marion, Marshall, Mercer, Monongalia, Ohio, Raleigh, and Wood. Id. at 32-43, 49; results of questionnaires sent to county health departments of all West Virginia counties by the author in connection with a health manpower study funded by the West Virginia Regional Medical program.

⁵Heinritz-Canterbury & Michael, supra note 1, at 7-17; results of questionnaires, supra note 3.

⁶Heinritz-Canterbury & Michael, supra note 1, at 7-17.

⁷Id.

⁸Id.
West Virginia's rural counties may not be especially lucrative relative to that in large metropolitan areas. Additionally, licensure laws, such as the citizenship requirement for foreign physicians, may deprive West Virginians of readily available health care. Furthermore, the licensure laws, with their strict penal sanctions, may constrain innovative procedures.

In recent years, West Virginia, along with a number of other states, has taken steps to alleviate the shortage of health care personnel. Potentially the most significant of these is the statutory legitimation of the "physician's assistant," a highly trained, skilled individual who is equipped to provide primary health care under the supervision of a licensed physician. This article will examine the PA concept, the nature of the West Virginia PA law, and problems of liability facing the PA and his supervising physician.

I. THE PHYSICIAN'S ASSISTANT CONCEPT

The development of a highly skilled PA is "[p]erhaps the most unique, rapidly growing, and controversial program" in American medicine today. The PA concept is premised on the idea that many tasks heretofore performed only by physicians can be performed equally well by specially trained health care professionals. If such a premise is valid, the PA offers great promise for improving health care and making such care more readily available.

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9In order to be licensed to practice medicine in West Virginia, a foreign physician must become a United States' citizen or give evidence of satisfactory progress toward becoming a citizen. W. Va. Code Ann. § 30-3-4 (1971 replacement volume).

10Foreign physicians accounted for one-third of the net increase in the physician population of the United States in 1970. Sodeman, The FMG and Licensure, 216 J.A.M.A. 1854 (1971). Furthermore, in the same year, 27% of the interns and 33% of the residents in the United States were foreign medical school graduates. Id. Of the sixty-five persons licensed to practice medicine in West Virginia in 1970, forty-eight were graduates of foreign medical schools. One hundred-fourteen foreign medical graduates took the licensing examination in that year, in contrast to only seventeen graduates of domestic medical schools. Report of the Council on Medical Educ. of the A.M.A., Medical Licensure Statistics for 1970, 216 J.A.M.A. 1783, 1808-13 (1971).


The major objective of all PA training programs is the improvement and extension of patient care. The designers of West Virginia's sole PA training program13 feel that a competent assist-

13Alderson-Broaddus College and Broaddus Hospital in Philippi operate the only PA training program in West Virginia. Although several PA programs are in operation throughout the United States, the A-B program was the first to provide a four year course of study—including liberal arts as well as vocational-professional courses—leading to the degree of bachelor of medical science. The Pittsburgh Press, Sept. 30, 1973, at 3. The first class, consisting of thirty students, was admitted in September, 1968. Myers, supra note 11, at 68. In addition to classroom studies, students are required to complete a clinical experience curriculum which runs from the end of the spring term of the student's junior year to the beginning of the spring term of his senior year. This block includes: (1) Twenty-four weeks of hospital experience, including surgery and outpatient care; (2) eight weeks divided between intensive care (two weeks) and three different specialties (two weeks each); and (3) four weeks experience working with a physician in private practice, Id. at 68. Broad statements about the program are risky, but those responsible for its design have reached the following general conclusions:

1. That the difference in the role between a physician's assistant and a nurse must be clearly defined. We have given this question considerable thought and have decided that the nurse is concerned primarily with personal medical care, whereas the physician's assistant is concerned mostly with diagnosis.

2. That where the role of the assistant overlaps that of other allied health personnel, a clear division of responsibility must be made. This has been resolved by assigning primary responsibility for specific tasks to one group and secondary responsibility only to the second group. For example, blood counts are always done by medical technologists, when and where they are available. Physician's assistants are taught to do blood counts but they would not do them except while learning as students, or when working in a physician's office where medical technologists were not available.

3. That students expect to receive an education which is complete in the aspects of health care in which they will be assisting, and that the level of instruction needs to be commensurate with their needs as graduates.

4. That providing adequately trained physician's assistants to overworked physicians is a practical method of helping preserve that part of medical practice known as the "art of medicine." It will give physicians more time to talk with patients and perhaps rekindle some of the warmth between them.

5. That it is necessary to find a way for students in the physician's assistant program who demonstrate superior qualifications to be admitted to medical school without a time penalty of more than a year.

6. That a deeply interested accredited university or college, with an accredited teaching hospital on the campus or in close proximity to it, is as necessary for the development and conduct of this program as it is for that of the other allied health programs. Cooperating institutions must have faculties and trustee boards with an innovative spirit.

7. That adequate outside funding for the first few years is highly desirable, if not absolutely essential.
ant can relieve a physician of at least thirty percent of his workload.14 Obviously, if this is so, a physician with such an assistant could greatly increase the number of patients he is able to treat.

The PA is conceived as "a health professional who works directly under the orders and supervision of a physician."15 This relationship implies a need on the part of the PA to develop values and attitudes common to physicians. Although the majority of the PA's assignments will be routine, his broad-based education qualifies him to assist the physician in many ways. Because of his comprehensive training, a PA may become a generalist, who acts as the physician's third arm, or a specialist in fields ranging from midwifery to surgical assistance.16

Although training programs are still too new to provide any definite answers, the PA offers great promise in several areas. Primarily, the PA is a creative solution to the nationwide shortage of health manpower.17 It is hypothesized that a major step could be taken toward reducing the current doctor shortage by using the PA to maximize the physician's effectiveness. Such routine functions

8. That a degree program, with an adequate amount of liberal studies, is as necessary as is the professional portion of the curriculum, if the physician's assistant is to be of maximal service.

Id. at 72. The concept of the physician's assistant offers great promise in providing more and better health care. The Alderson-Broaddus program is a major step in the direction of providing better health care for all West Virginians.

16Myers, supra note 11, at 69.

17Id.

18Comment, The Physician's Assistant in California—A Better Legal Framework, 12 SANTA CLARA LAW. 107, 108 (1972) [hereinafter cited as The Physician's Assistant]. One study has separated PAs into three categories. The type A PA is capable of collecting data, both historical and physical, and organizing and presenting it in such a fashion as to allow a physician to visualize the problem, make the proper diagnosis, and determine the steps to be taken. He is capable of aiding the physician by performing certain diagnostic and therapeutic procedures and may function outside the direct supervision of the physician. The type B PA has less general knowledge and skill than a type A PA relative to the whole range of medical care. However, he has usually developed exceptional skill in a particular clinical specialty or an area within that specialty. He is less qualified for independent action than his type A counterpart. PAs in the final category—type C—function in roughly the same relationship to medicine as the practical nurse does to nursing. This type of PA is capable of performing a variety of tasks but is not capable of integrating and interpreting his findings. The type C PA requires close supervision by the physician-employer. Sadler & Sadler, Recent Developments in the Law Relating to the Physician's Assistant, 24 VAND. L. REV. 1183 (1971). The West Virginia statute appears flexible enough to allow all three types of PAs to practice. W. VA. CODE ANN. §§ 30-3A-1 to 4 (1971 replacement volume).

16SADLER, SADLER & BLISS, supra note 12, at 13-16.
as patient history, physical examinations, and certain diagnostic and therapeutic procedures can be adequately, if not more effectively, performed by the PA.\textsuperscript{16}

The PA program is also of potential economic value as a source of civilian jobs for returning servicemen.\textsuperscript{19} Each year, some thirty thousand men with some medical experience are discharged from the armed services.\textsuperscript{20} Additionally, the utilization of PAs should help both to reduce the rising costs of medical education and to lower the cost of medical care to the consumer.\textsuperscript{21} More importantly, the PA is seen as the key to improvement in the quality of medical care.\textsuperscript{22} Thus, greater numbers of patients may be able to receive care under more favorable conditions, and more accurate diagnosis may be facilitated by less hurried examinations.

Although few would take exception to these goals, undoubtedly they will not be met until large numbers of PAs are produced. The demand for the few trained PAs available is so great that few "end up in primary care or rural settings where the need is the greatest."\textsuperscript{23} As of 1971, only two hundred PAs existed in the United States,\textsuperscript{24} but the shortage may be easily remedied. In 1970 alone, over thirteen thousand persons were denied admission to medical schools in the United States.\textsuperscript{25} In addition, many college graduates might be interested in the field of medicine, but unwilling or unable to undertake the lengthy and expensive training necessary to

\textsuperscript{16}Id.
\textsuperscript{19}Id.
\textsuperscript{20}The Veteran Medic Group (VMG) is actively pushing for participation in the PA program in West Virginia. The VMG sought State participation in the National Medex program in the 1973 Legislature. The Morgantown Post, Friday, May 4, 1973, at 12-B. This proposal died, however, in the House Finance Committee. Nevertheless, a committee within the State Department of Employment Security is seeking federal funding for the program, which envisions the medic as staffing rural primary-care diagnostic clinics and performing other services. Id. The proposed West Virginia Medex program is composed exclusively of on-the-job training. Id. In contrast, several other state programs require academic training. For example, the program at the University of Washington requires three months of university-based education and twelve months on-the-job training under the supervision of a practicing physician. Here, too, the emphasis is on "primary care practice in rural areas." SADLER, SADLER & BLISS, supra note 12, at 20-21.
\textsuperscript{21}SADLER, SADLER & BLISS, supra note 12, at 9.
\textsuperscript{22}Id.
\textsuperscript{23}Id. at 29.
\textsuperscript{24}The Alderson-Broaddus program begin in 1968, and the first class graduated in 1972. See the discussion in note 13 supra.
\textsuperscript{25}SADLER, SADLER & BLISS, supra note 12, at 17-18.
qualify as a physician. Finally, other health care professionals might desire to expand their opportunities and responsibilities.26

So it appears that a ready supply of potential PAs is available. The chief stumbling block, then, is acceptance of the PA by the patient and the physician. Patients should come to accept the PA with no great difficulty, since nurses, medical technicians, therapists, and other auxiliary personnel have gained wide acceptance by the public. Especially in rural areas where there is a great shortage of physicians, the PA should experience few problems with acceptance by the public.

Acceptance by physicians is less certain. A relatively recent nationwide survey showed that sixty-one percent of the physicians responding favored the PA concept, but only forty-two percent said they would use one.27 Perhaps the biggest drawback is the feeling of many physicians that the use of PAs may increase potential

26Id.

27Coye & Hansen, The Doctor’s Assistant, 209 J.A.M.A. 529-33 (1969). A survey taken in West Virginia produced similar results. One hundred two physicians responded to a random survey by the Division of Public Health and Preventive Medicine of the West Virginia University School of Medicine. This represented approximately a fifty percent response. The results of the survey were as follows:

(1) Would a person trained to do routine physical exams and follow up of simple problems under your direction (nurse practitioner, P.A., MEDEX, etc.) be helpful to reduce the time-load and/or provide services not now available to all your patients? Yes- 31; No- 48; Undecided- 21; No answer- 2. (2) Would you be interested in hiring such a person? Yes- 24; No- 60; Undecided- 15; No answer- 3. (3) If yes, how much would you be willing to pay such a person per month? $400-1; $500-1; $600-1; $750-1; $800-5; $900 -1; $1000-1; $1200-1; $1500-2; Undecided- 24; No answer- 64.

In addition, a survey of the 220 members of the West Virginia Academy of Family Practice (about one-half of the total number of general practitioners in the State) produced the following results:

(1) One hundred thirty did not answer; (2) forty-six were not interested; (3) seventeen wanted more information; (4) eleven were willing to be on a State planning committee; (5) sixteen were willing to be preceptors; and (6) fourteen were interested in the possibility of hiring a PA now.

These totals include some multiple answers.

Telephone interview with Dr. Walter Morgan, chairman of the Division of Public Health and Preventive Medicine, West Virginia University School of Medicine, in Morgantown, West Virginia, Jan. 10, 1974. Although the above surveys tend to indicate a present lack of support among physicians for the idea of the physician’s assistant, Dr. Morgan believes that there is a significant nucleus of physicians who are at least interested in exploring the area. In addition, Dr. Morgan indicated a belief that no strongly negative sentiment existed against the physician’s assistant concept.
liability for malpractice.\textsuperscript{28}

The increasing availability of insurance, which insulates the physician from liability for his PA’s negligent acts, is certain to diminish potential tort liability as a factor influencing the hiring of PAs. Although existing case law indicates that the normal physician’s malpractice insurance policy does not protect the physician against vicarious liability for his PA’s acts,\textsuperscript{29} an endorsement is available, providing increased coverage at a nominal cost.\textsuperscript{30} In addition, the PA may insure himself against liability at a reasonable rate.\textsuperscript{31}

II. The West Virginia Statute

The West Virginia "Assistants to Physicians" law\textsuperscript{32} is brief and concise; in short, it represents a model piece of legislation. Under the West Virginia law, a PA is defined as "a person employed in a physician’s or podiatrist’s office, licensed hospital or any licensed health care institution who performs selected medical tasks and functions in accordance with an approved job description, and who possesses the qualifications which have been established for the prescribed job."\textsuperscript{33} The PA must practice under the supervision of a licensed physician or podiatrist.\textsuperscript{34} In order to employ a PA, a physician or institution must submit a job description for approval by the medical licensing board of West Virginia.\textsuperscript{35} A job description can be modified with the board’s approval at any time. Obviously, such a procedure vests the ultimate responsibility for the law’s success or failure with the members of the medical licensing board, and a board disposed to do so could frustrate the

\textsuperscript{28}The truth, however, may be just the opposite. For a discussion of this idea, see the text accompanying note 64 infra.
\textsuperscript{29}Glesby v. Hartford Acc. & Indem. Co., 6 Cal. App. 2d 89, 44 P.2d 365 (1936); Betts v. Massachusetts Bonding & Ins. Co., 90 N.J.L. 632, 101 A. 257 (1917). These cases, however, were decided before the advent of physician’s assistant laws and may no longer be applicable.
\textsuperscript{31}Id. The current rate for malpractice coverage of $250,000 - $500,000 is approximately $175 per year. Only one such policy has been written by Aetna in West Virginia.
\textsuperscript{32}W. VA. CODE ANN. §§ 30-3A-1 to -4 (1971 replacement volume).
\textsuperscript{33}Id. § 1.
\textsuperscript{34}Id.
\textsuperscript{35}Id. § 2. Each time a physician submits a job description for approval by the board, he must also tender a fee of fifty dollars. Id. § 3.
legislative intent. This danger, however, seems slight in comparison with the great degree of flexibility that the statute provides.

A PA is certified rather than licensed by the medical licensing board, and his certification must be renewed annually. Within the scope of his job description, the PA can operate with considerable flexibility. A statute of this type allows the PA to exercise independent judgment over matters he is qualified to handle. The

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23Id. § 2.
24The annual renewal fee is five dollars. Id. § 3.
25The only restrictions in the statute provide that the PA may neither sign prescriptions nor perform any service which his supervising physician would not be qualified to perform. Id. § 4.
26Two other states have adopted statutes essentially identical to the West Virginia law. N.C. GEN. STAT. § 90-18 (1965); VT. STAT. ANN. tit. 26, §§ 1725-29 (1967). A number of other states also have laws authorizing PAs. Five states merely exempt the PA from the effect of licensure laws, with control vested in the physician. Utah and Massachusetts require registration by the PA with the medical licensing board. UTAH CODE ANN. § 88-12-40 (1963); MASS. GEN. LAWS ANN. ch. 112, § 9A (1965). A PA in Massachusetts must have completed two years of medical school. The other three statutes contain no such requirements. ALASKA STAT. §§ 08.64.170, .360 (1973); ARIZ. REV. STAT. ANN. § 32-1421(6) (1956); COLO. REV. STAT. ANN. § 91-1-6(3)(m) (1964). The majority of state statutes specifically prohibit the PA from performing certain functions. The Florida statute permits the PA to function somewhat independently within the physician's office. Beyond this, he may function only when the physician is present, in a hospital where the supervising physician has staff privileges, and on calls outside the physician's office or hospital only when responding to the direct order of the physician. FLA. STAT. ANN. § 458.135 (1965). Georgia law requires that medical tasks be performed only in the presence of the physician and under his direct supervision. GA. CODE ANN. §§ 84-6201 to 6209 (1970). Oregon forbids the exercise of independent judgment by the PA except in life-threatening emergencies. ORE. REV. STAT. §§ 677.012, .055, .065, .090, .232, .255, .510 (1971). Virginia restricts the PA's services to activities of an educational, diagnostic, therapeutic, or preventive nature. No final diagnosis or plan of treatment is permitted to be given by an assistant. In addition, the PA is prohibited from prescribing or dispensing drugs. VA. CODE ANN. §§ 54-281.4 to .9 (1972). Six other states either forbid the measurement of the eye and fitting of glasses or contact lenses, as well as the prescription or direction of the use of any optical device, or permit such activity only under the direct supervision of the physician. ALA. CODE tit. 46, §§ 297(2ajj)-297(2nn) (1958); CAL. BUS. & PROF. CODE §§ 2510-2522 (Deering Cum. Supp. 1973); CONN. GEN. STAT. ANN. § 20-9 (1969); IOWA CODE ANN. § 148B.9 (1972); OKLA. STAT. ANN. tit. 59, § 521 (1971); WASH. REV. CODE ANN. §§ 18.71A.010-18.71A.060 (1961). In addition, the California statute specifically bars the assistant from practicing dentistry. The Washington statute incorporates this exception and also bars the practice of dental hygiene, chiropractic, and chiropody. A final type of statute limits the PA to practice in a particular specialty. COLO. REV. STAT. ANN. § 91-10-1 to 15 (Cum. Supp. 1969). The Colorado Child Health Associate Law is the most restrictive law relating to PAs currently in effect in the United States. Only a
West Virginia PA law is a model for laws of its kind in the United States. It provides maximum protection from liability for both the PA and the physician consistent with maintaining the necessary freedom to enable the PA to perform a valuable service for the health care consumer.

III. PROBLEMS OF LIABILITY

The intrusion of the PA into the health manpower scheme creates several problems of liability, both for the physician and the assistant. The PA is, of course, liable for his own negligent acts. Perhaps the most immediate problem is one of misrepresentation. The question of the PA's responsibility to make his status known to the patient is closely analogous to the established doctrine of "informed consent." This doctrine has generally been applied to the physician-patient relationship. The basis of the doctrine is the principle that, absent a dire emergency, a physician may not perform any act on a patient without consent. A physician acting without consent, albeit properly, commits a battery.

Little imagination is required to envision the extension of the "informed consent" doctrine to the PA's relationships with his employer's patients. The patient must be made aware that he is being treated or examined by a PA rather than by a licensed physician. This conclusion is buttressed by the West Virginia Code provision that an individual who holds himself out as capable of physician whose primary practice is in the field of pediatrics may employ such an assistant. The child health associate must meet certain requirements including serving an internship and passing an examination. In addition, the supervising physician must be approved by the medical licensing board. The associate is limited to practicing in the professional office of the employing physician and under the physician's direct personal supervision. In addition, he may perform pediatric services outside the physician's office if under the direct personal supervision of his employer. The associate may prescribe only those drugs specifically delineated in the statute.

The doctrine of "informed consent" is "a theory in medical malpractice which allows a cause of action to a person who consents to medical treatment without first having been adequately informed as to the nature and consequences of the attendant risks." Jacobson, Informed Consent in Illinois, 18 DePaul L. Rev. 458 (1969). No West Virginia cases have been found which mention "informed consent" specifically, but the principle is generally accepted throughout the United States.


The Physician's Assistant, supra note 16, at 114.
practicing medicine, although not a licensed physician, is guilty of a misdemeanor.44 While it is questionable whether criminal penalties would be invoked against a PA who makes no active misrepresentation, a patient who consents to treatment by a PA without notice of the PA's status may be deemed not to have consented and, therefore, be entitled to sue for battery.45

The type of consent necessary is uncertain. PAs might wear large badges signifying their status or require patients to sign consent forms.46 More simply, the PA's obligation should be satisfied by merely communicating, in whatever fashion, his status to the patient.

A second, and perhaps more significant, problem of liability is the standard of care which the PA must meet. A licensed physician in West Virginia is required to exercise such reasonable and ordinary skill and diligence as are ordinarily possessed and exercised by the average of the members of the profession in good standing, in similar localities and in the same general line of practice, regard being had to the state of medical science at the time.47

The "locality rule" also applies generally to practitioners of other licensed professions. Thus, if the traditional approach is followed strictly, the PA would be held to the standard of care of the average

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46The Physician's Assistant, supra note 16, at 114.
47Dye v. Corbin, 59 W. Va. 266, 270, 53 S.E. 147, 149 (1906). This so-called "locality rule" was first developed in Massachusetts. Small v. Howard, 128 Mass. 131 (1880). It was applied uniformly and without exception in West Virginia until 1987. Schroeder v. Adkins, 149 W. Va. 400, 411 S.E.2d 352 (1965); Vaughan v. Memorial Hosp., 103 W. Va. 156, 136 S.E. 837 (1927); Meadows v. McCullough, 101 W. Va. 103, 132 S.E. 194 (1926); Vaughan v. Memorial Hosp., 100 W. Va. 290, 130 S.E. 481 (1925). Then, in Hundley v. Martinez, 151 W. Va. 977, 158 S.E.2d 159 (1967), the court modified the "locality rule," noting the national trend toward imposing a higher standard of care. Although refusing to abrogate the rule entirely, the court noted that where a physician is a specialist in a particular field, he, of necessity, is trained in the latest procedures used in his specialty. "He must, therefore, be charged with a higher degree of skill and knowledge in the treatment of [his specialty] than the physician without such additional training." The court then determined to hold the specialist responsible for knowledge of standard procedures utilized in his specialty throughout the country. Id. at 994-95, 158 S.E.2d at 169. The opinion in Hundley seems to indicate a willingness on the part of the court to move toward a national standard for the entire medical profession. Such a nationwide standard would presumably also apply to the physician's assistant.
PA under the same or similar circumstances. In the alternative, the courts may hold the PA to the same standard of care as the physician.

There is no general agreement as to which standard of care is most feasible, and the West Virginia court has had no occasion to rule on the matter. Application of the standard of care of the community of licensed physicians insures that the standard required by tort law will not be relaxed. If the PA is viewed primarily as a means of increasing the health manpower supply, then a compromised tort standard may be justified. To offset this reduction, one study has suggested that quality control can be achieved by stricter certification requirements for the PA. However, such a suggestion ignores the seemingly evident fact that stricter certification procedures may also reduce the supply of PAs.

On the other side of the coin, many commentators argue strongly for application of the standard of care of the community of licensed physicians. This view is based on the presumption that the quality of health care is as important as its availability and that, perhaps, neither need be sacrificed. Strengthening this argument is the fact that the PA is not licensed as are other health care professionals. He is viewed, in effect, as an extension of the physician, thus making it reasonable to hold him to the same standard of care. In the words of one writer:

To hold P.A.s to a lower standard of care than physicians would be legal recognition of a lowering of the quality of care patients would be receiving. This would also remove a stimulus, which would otherwise be present, for the attainment of excellence in P.A. training programs. By holding the P.A. to the same standard of care as the physician, the doctrine of respondeat superior should work to maximize supervision. A physician will delegate only where he is sure the P.A. can do a physician-like job, and he will supervise carefully to make sure the P.A. is performing capably.

Application of the physician's standard of care to the PA appears to be more consistent with the protection of the public than the alternative standard. In any event, there is no hard evidence that

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Note, Tort Liability and the California Health Care Assistant, 45 S. Cal. L. Rev. 768, 774 (1972) [hereinafter cited as Tort Liability].

Id. at 775.

Id.

The Physician's Assistant, supra note 16, at 115.

Id. at 115-16.
the adoption of this standard would significantly affect the available supply of PAs.

In addition to the problems of liability discussed supra, the PA may also be under another duty—the duty to refer.53 Since the PA will normally see the patient first, he must accept the responsibility of deciding when to refer the patient to the physician. Proper referral is of great importance in achieving quality health care, and failure of the PA to refer a patient may, under certain circumstances, result in liability for negligence.54 Again, though, the PA should only be held to the standard of the average physician in determining whether to refer. Thus, the standard is not one of strict liability, and liability should be imposed only where there is evidence of a negligent failure to refer.

The discussion to this point has dealt exclusively with potential liability problems of the PA. However, the physician may also incur liability from the PA’s negligent acts. The possibility of increased liability, whether real or imagined, presents the greatest obstacle to effective utilization of the PA.

The physician’s liability is based on the doctrine of respondeat superior,55 which holds the physician liable for the wrongful acts of his employees, even if the physician’s conduct is without fault.56 Before any liability can attach, a master-servant relationship must exist between the physician and his assistant,57 and the negligent act of the employee must have occurred within the scope of his employment.58

That a master-servant relationship exists between a physician and his assistant is indisputable. The PA statute requires supervision of the assistant by the physician and gives the physician control over the PA’s activities.59 Since, under West Virginia law, the

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53Tort Liability, supra note 48, at 776.
54For example, an industrial nurse was held liable for negligent failure to determine that the patient’s condition required the care of a physician. Cooper v. National Motor Bearing Co., 136 Cal. App. 2d 229, 288 P.2d 581 (1955). For a general treatment of the duty to refer, see Tort Liability, supra note 48, at 776.
55This doctrine holds the master liable for torts committed by the servant acting in the course of his employment. Eggleston v. Tanner, 86 W. Va. 385, 103 S.E. 113 (1920); Vance v. Frantz, 83 W. Va. 671, 99 S.E. 12 (1919); Jenkins v. Montgomery, 69 W. Va. 795, 72 S.E. 1087 (1911).
57IIA HOSPITAL LAW MANUAL 7 (1972).
58Id.
59W. VA. CODE ANN. § 30-3A-1 (1971 replacement volume). In determining whether a master-servant relationship exists, the right to control the physical move-
PA functions as an extension of the physician, the negligent act of the assistant will be imputed to his employer according to the principle *qui facit per alium facit per se.*

The physician is also under a duty to use due care in the selection of an assistant. Since the medical licensing board merely certifies the PA upon submission of a job description by the physician, the physician has primary responsibility for the qualifications of the person he employs. It has been suggested that the doctrine of respondeat superior should be replaced by a greater reliance on this duty and the consequent duty of due care in the supervision of the assistant. Under this view, if due care is used in selecting an assistant and proper supervision is maintained, the physician would not be held liable for his assistant’s negligent acts. While this suggestion may have merit, respondeat superior is firmly entrenched in West Virginia law, and a retreat from its principles seems unlikely in the foreseeable future.

Perhaps a more feasible suggestion involves a partial departure from respondeat superior:

Where the physician assistant is delegated a medical task which requires his own exercise of professional judgement and skill, he alone should be held to bear the burden of liability. When merely acting as an extension of the physician’s hands in performing under specific instructions, however, he could be held liable only for a lack of skill in execution, the physician being held liable where the function, though correctly performed, was medically improper.

It must be emphasized, however, that even this slight departure

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from the doctrine of respondeat superior has yet to find official sanction.

IV. Conclusion

It is difficult to say whether use of the PA actually will increase the risk of malpractice liability for the physician. Certainly many physicians fear that it will. However, one commentator has concluded that the utilization of PAs will, in fact, reduce malpractice risks:

First, effective utilization of P.A.s will allow the physician to concentrate on those medical procedures and judgements that only he can manage. Second, a malpractice suit often results from poor patient rapport rather than negligence per se. When a patient is seen after a considerable wait and then only hurriedly by a harassed physician, the probability of patient dissatisfaction is magnified. Time-motion studies have shown that, when a physician’s assistant is used, waiting periods are reduced, patients receive greater attention from various health care professionals, and patient acceptance of the P.A. has generally been good.\textsuperscript{44}

It appears, then, that the emergence of the PA poses no new legal problems for the physician, but merely more of the same problems caused by the utilization of nurses and other auxiliary health care personnel. At best, the PA may actually serve to reduce the physician’s risk of liability. At worst, the potential liability is not so great as to deter the use of this new type of health care professional.

Certainly, the promise of the PA is bright. Whether assisting a physician in a busy metropolitan practice or providing primary health care in a rural clinic, the PA offers new hope of adequate medical care for all West Virginians. The only substantial obstacle that remains is acceptance of the PA by physicians. Hopefully, the obvious benefits of utilizing an assistant will eventually overcome the physician’s fear of increased liability.

\textit{Joseph S. Beeson}

\textsuperscript{44}\textit{Sadler, Sadler & Bliss, supra note 12, at 81-82.}