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MEDICO-LEGAL IMPLICATIONS OF RECENT LEGISLATION CONCERNING ALLIED HEALTH PRACTITIONERS*

I. INTRODUCTION

The shortage of primary care physicians¹ and the growing consumer demand² for quality health care have been major factors contributing to the need for the two types of allied health practitioners³ known as

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1. See Andrus & Fenley, *Assistants to Primary Physicians in California*, 122 W.J. MED. 80 (1975); Jones & Hamburger, *Physician Supply in California*, 123 W.J. MED. 250 (1975). See also CALIFORNIA HEALTH MANPOWER POLICY COMMISSION, THIRD ANNUAL REPORT TO THE CALIFORNIA LEGISLATURE 1 (1976) [hereinafter cited as CALIFORNIA HEALTH MANPOWER REPORT].

2. See A. FORD, *THE PHYSICIAN'S ASSISTANT* 35-36 (1975); Lawrence & Callen, *The Demand for New Health Practitioners*, in *NEW HEALTH PRACTITIONERS* 13 (Nat'l Insts. of Health, DHEW Pub. No. 75-875, 1974).

3. This category of health worker evolved in response to the paucity of doctors and the resulting inability of the medical profession to deliver needed health care to many California residents. See note 7 *infra*. The allied health practitioners are neither replacing the physician nor providing a substitute for medical care. Rather, they are bringing physicians' services into areas which otherwise would probably not be reached due to the shortage and maldistribution of physicians. See note 1 *supra*. They represent a viable means of meeting the health care needs of the people of the state. For an interesting discussion of the development of allied practitioners in California, see Ver Steeg, *Development of Physician's Assistants and Nurse Practitioners in California*, 51 BULL. N.Y. ACAD. MED. 286 (1975).

Discussions of allied health practitioners, also known as midlevel medical practitioners, must include both nurse practitioners and physician's assistants. These two occupational titles are currently the most widely accepted in the health field. Throughout this comment, physician's assistants and nurse practitioners will be discussed in their respective roles as providers of health care.

The use of allied health practitioners to reduce costs and solve manpower shortages in the field of health care parallels the innovative use by the legal profession of legal paraprofessionals to assist lawyers in supplying legal services. Just as the allied health practitioner is not legally entitled to engage in the independent practice of medicine, the legal paraprofessional is not qualified to engage in the independent practice of law, but must be supervised and controlled by a licensed member of the legal profession. See generally Brickman, *Expansion of the Lawyering Process Through a New Delivery System: The Emergence and State of Legal Paraprofessionalism*, 71 COLUM. L. REV. 1153 (1971); Brown, *Preventive Law and the Legal Assistant*, 24 VAND. L. REV. 1181 (1971); Early, *The Need for Legal Nurses*, 74 CASE & COM. 34 (Sept.-Oct. 1969); Smith, *Vertical Expansion of the Legal Services Team*, 56 A.B.A.J. 664 (1970).

physician's assistants⁴ and nurse practitioners.⁵ Coupled with a maldistribution of physicians,⁶ these factors have resulted in inadequate health care in some areas of California,⁷ particularly in rural and inner city areas.⁸

California laws and regulations have kept a tight rein on physician's assistants and nurse practitioners.⁹ Recently, however, efforts have been

4. There are different specialty levels of physician's assistants, *see* note 81 *infra*, but for the purposes of this comment, physician's assistants are assistants to the primary care physician. They are usually generalists, able to perform varied procedures, and the first persons to come into contact with the patient. They can increase the physician's efficiency and effectiveness by performing tasks that are often time consuming and repetitious. Additionally, physician's assistants can be trained in a relatively short period of time, thereby increasing the availability of health manpower. They can perform many medical tasks traditionally performed by physicians, but not requiring their extensive skill and knowledge, and can be placed in shortage areas.

Nationally, the concept of the physician's assistant has been fully supported by the federal government. A. SADLER, B. SADLER, & A. BLISS, *THE PHYSICIAN'S ASSISTANT—TODAY AND TOMORROW* 1-2 (1975). *See also* Fox & Cooper, *Federal Policy Issues in the Introduction and Long-Term Support of Physician Extenders*, in *INTERMEDIATE-LEVEL HEALTH PRACTITIONERS* 14 (1973).

5. The term nurse practitioner has been variously used. Advisory Comm. on Physician's Assistant and Nurse Practitioner Programs, *The Development, Education, and Utilization of Nurse Practitioners in the State of California* 14 (final report, Dec. 4, 1973). In this comment, reference to nurse practitioners encompasses registered nurses operating in an expanded role in giving primary care. Such health care providers have training beyond that required of registered nurses. They can deliver primary health and medical care pursuant to the California Nursing Practice Act, CAL. BUS. & PROF. CODE §§ 2700-2830 (West 1974 & Supp. 1978). They have the ability to "[a]ssess the health status of individuals and families through health and medical history taking, physical examinations, and defining of health and developmental problems." CALIFORNIA HEALTH MANPOWER REPORT, *supra* note 1, at 25. This definition was adopted by the Health Manpower Policy Commission because there is currently no legally defined entity entitled "nurse practitioner" in California. *See* Law of Aug. 29, 1977, ch. 439, § 2, [1977] Cal. Stats. ____ (codified at CAL. BUS. & PROF. CODE §§ 2834-2837). Nurse practitioners can significantly decrease the cost of health care without sacrificing quality. V. HALL, *STATUTORY REGULATION OF THE SCOPE OF NURSING PRACTICE—A CRITICAL SURVEY* 3 (1975).

6. CALIFORNIA HEALTH MANPOWER REPORT, *supra* note 1, at 1. *See also* Jones & Hamburger, *Physician Supply in California*, 123 W.J. MED. 250 (1975).

7. According to projections, California is not training sufficient numbers of family physicians to counterbalance the state's shortage. Even more disheartening is the belief of state health leaders that, at the current rate residents are being trained, California's shortage will become greater every year. CALIFORNIA HEALTH MANPOWER POLICY COMMISSION, *SECOND ANNUAL REPORT TO THE CALIFORNIA LEGISLATURE* 22 (Dec. 15, 1975). *See also* Jones & Hamburger, *Physician Supply in California*, 123 W.J. MED. 250 (1975).

8. CALIFORNIA HEALTH MANPOWER REPORT, *supra* note 1, at 2. *See generally* J. ACTON, *DEMAND FOR HEALTH CARE AMONG THE URBAN POOR, WITH SPECIAL EMPHASIS ON THE ROLE OF TIME* (RAND Corp. No. 1151, 1973).

9. For a discussion of these laws and some examples and evidence that they remain overly restrictive with respect to widespread usage of physician's assistants and nurse practitioners, *see* Oseran, *Physician's Assistants in California*, 124 W.J. MED. 258, 262

made to reduce the constraints imposed by those laws.¹⁰ In the face of growing demands being made on our health care system,¹¹ state health and government leaders have become increasingly concerned about the shortage and maldistribution of health care personnel.¹² They recognize that both physician's assistants and nurse practitioners hold great potential for the improvement of health care services in underserved rural and inner city areas.¹³ Further, they are eager to have these allied health practitioners assume greater responsibility for patient welfare in health care deficient areas.¹⁴

With the recent enactment of Assembly Bill 717 (A.B. 717),¹⁵ the legislature took a major step in encouraging the widespread utilization of physician's assistants and nurse practitioners.¹⁶ The law authorizes a pilot project¹⁷ permitting the prescription, dispensation, and administration of

(1976). "Legal problems associated with the use of a PA [physician's assistant] or NP [nurse practitioner] have been cited as potential obstacles to the acceptance and full utilization of these new health providers." A. FORD, *THE PHYSICIAN'S ASSISTANT* 113 (1975).

10. Legislative proposals regarding the expanded use of allied health practitioners have been enacted in several other states, including Michigan. Physician's Assistants Act, MICH. COMP. LAWS §§ 338.1951-1978 (MICH. STAT. ANN. §§ 14.718(11)-(38) (Callaghan 1977)). The Michigan law enables physician's assistants to give various medical treatments under direct or radio contact with a physician, conduct physical examinations, suture minor wounds, administer certain tests, apply or remove casts, and write prescriptions for all drugs except controlled substances. *Id.* § 338.1967 (MICH. STAT. ANN. § 14.718(27)).

11. CALIFORNIA HEALTH MANPOWER REPORT, *supra* note 1, at 2.

12. See CAL. HEALTH & SAFETY CODE § 1185 (West Supp. 1978) (requiring State Department of Health to implement program of health services development projects to remedy deficiencies in health services in rural areas). The statement of intent declares that "[t]here is a maldistribution of health services in California. Most rural areas of the state do not have adequate health services because there are insufficient health personnel. . . . It is unlikely that the situation will improve without substantial state and local action." *Id.* § 1185(a), (d).

13. CAL. EDUC. CODE § 31910 (West 1976). See CALIFORNIA HEALTH MANPOWER REPORT, *supra* note 1, at 2; Benton, *Allied Health Personnel and Health-Manpower Problems*, 52 BULL. N.Y. ACAD. MED. 1144, 1144-45 (1976).

14. See Andrus & Fenley, *Assistants to Primary Physicians in California*, 122 W.J. MED. 80, 81 (1975).

15. Law of Sept. 15, 1977, ch. 843, §§ 1-25, [1977] Cal. Stats. ____ (codified in scattered sections of CAL. BUS. & PROF. CODE and CAL. HEALTH & SAFETY CODE).

16. One of the major concerns in the training of allied health practitioners is whether they will actually work in the geographical areas where there is the most medical need. With the enactment of A.B. 717, those practitioners will be able to perform in medically underserved areas the functions for which they were trained. But it remains to be seen whether they will be deployed to, or remain in, those areas where they are most needed.

17. A health manpower pilot project is, for the purposes of A.B. 717, an educational or training program approved by the California Department of Health. Once the Department of Health approves the project, those persons who are to be taught the health care skills are thereafter empowered to perform "health care services" under the

specific drugs or devices¹⁸ by physician's assistants and by registered nurses¹⁹ operating in expanded roles as nurse practitioners,²⁰ under the "general supervision" of a licensed physician.²¹ Reflecting the legislature's understanding of the need for primary health care in medically underserved areas, A.B. 717 requires that projects which operate in rural and central city areas be given priority.²² Under existing California law, physician's assistants and nurse practitioners have not been sanctioned to prescribe, dispense, or administer drugs; to permit them to do so has been a violation of the law.²³ With legislative approbation, the physician

general supervision of their supervisor. *See* Law of Sept. 15, 1977, ch. 843, §§ 1-25, [1977] Cal. Stats. ____ (codified in scattered sections of CAL. BUS. & PROF. CODE and CAL. HEALTH & SAFETY CODE). The Department of Health may, on a pilot program basis, either (1) teach new skills to existing categories of health personnel, or (2) accelerate the training of existing categories of health care personnel. *Id.* § 13 (codified at CAL. HEALTH & SAFETY CODE § 429.71).

18. A device is defined as:

any instrument, apparatus, or contrivance, including any component, part, product, or by-product of a device, or accessory, which is used, or intended for use, for any of the following:

- (a) In the diagnosis, cure, mitigation, treatment, or prevention of disease in man or any other animal.
- (b) To affect the structure or any function of the body of man or any other animal.

CAL. HEALTH & SAFETY CODE § 26009 (West Supp. 1978). *See also* STEDMAN'S MEDICAL DICTIONARY 383 (4th Law. ed. 1976). For a discussion of paramedical practitioners and the use of medical devices, see Leff, *Medical Devices and Paramedical Personnel: A Preliminary Context for Emerging Problems*, 1967 WASH. U.L.Q. 332.

19. The bill would also permit pharmacists to carry out the same functions. Law of Sept. 15, 1977, ch. 843, § 5, [1977] Cal. Stats. ____ (codified at CAL. BUS. & PROF. CODE § 4037.1). This comment, however, confines itself to allied health practitioners.

20. The language of the bill specifies registered nurses. However, it deals in reality with only those registered nurses operating in expanded roles, that is, nurse practitioners. Interview with Dale Houghland, Chief, Office of Health Professions Development, California State Department of Health, in Ventura, California (Aug. 3, 1977). The reason for the wording of the bill is that, at the time of its last senate hearing, California law made no provision for the use of the term "nurse practitioner." *See* Law of Aug. 29, 1977, ch. 439, § 2, [1977] Cal. Stats. ____ (codified at CAL. BUS. & PROF. CODE §§ 2834-2837). However, the legislature has found that the public interest would be served by determination of the legitimate use of the title "nurse practitioner" by registered nurses. *Id.* The California Board of Nursing Education and Nurse Registration must establish categories of nurse practitioners and standards for use of the term. *Id.* The law should bring an end to the various conflicting definitions of the nurse practitioner that have been created by state agencies and private organizations within California. *Id.* Further support for the contention that A.B. 717 refers to expanded role nurse practitioners is found in the law itself. The law states that pilot projects may be approved for expanded role medical auxiliaries and expanded role nursing. Law of Sept. 15, 1977, ch. 843, § 14, [1977] Cal. Stats. ____ (codified at CAL. HEALTH & SAFETY CODE § 429.77).

21. Law of Sept. 15, 1977, ch. 843, §§ 1, 2, [1977] Cal. Stats. ____ (codified at CAL. BUS. & PROF. CODE §§ 2725.1, 3502.1).

22. *Id.* § 14 (codified at CAL. HEALTH & SAFETY CODE § 429.77).

23. "No person other than a physician, dentist, podiatrist or veterinarian shall prescribe or write a prescription." CAL. BUS. & PROF. CODE § 4036 (West 1975). But note that

will be freed of the risk of illegally²⁴ delegating those responsibilities.

Still, a major problem in extending the scope of an established health profession is the attendant civil liability. In order to assist the practicing attorney in gaining a proper perspective of the effect of this recent legislation, this comment will assess the provisions of A.B. 717 and examine the potential medico-legal significance of the bill. Theories of liability will be discussed, with emphasis on California law.

II. SIGNIFICANCE OF THE "GENERAL SUPERVISION" REQUIREMENT

A major factor in the efficient utilization of allied health personnel is that of supervision. A.B. 717 specifically calls for "general supervision,"²⁵ which is a nebulous concept. Use of such an undefined term provides flexibility,²⁶ allowing the regulatory agencies to meet problems that may develop, but it also raises problems in practical application. Does "general supervision" mean physical presence or something less? If only "general supervision" is required, will the supervising physician have the ultimate legal responsibility for the activities of the allied health practitioner? Does "general supervision" imply that a physician's assistant or a nurse practitioner will be exercising independent judgment in prescribing treatments and drugs? Such questions must be addressed

if the dispensation or administration of drugs is authorized by a pilot project, California law presently allows an allied health practitioner to dispense or administer drugs upon a valid prescription from a person licensed to prescribe drugs. California Department of Health Legal Opinion from Charles M. Bonneau, Office of Legal Affairs, to Dale Houghland, Chief, Health Manpower Development Section (April 23, 1976) (copy on file in the office of the Loyola of Los Angeles Law Review). A.B. 717 alters the limitations of § 4036 by permitting either a registered nurse or a physician's assistant acting within the scope of an authorized project to prescribe or write a prescription. Law of Sept. 15, 1977, ch. 843, § 4, [1977] Cal. Stats. ____ (codified at CAL. BUS. & PROF. CODE § 4036). Thus, the legislation will extend the range of services that the allied health practitioner can provide.

24. Although A.B. 717 will not overturn existing statutory prohibitions against the prescribing of drugs by non-physicians, *see* note 23 *supra*, it provides an exception to those prohibitions. Law of Sept. 15, 1977, ch. 843, § 4, [1977] Cal. Stats. ____ (codified at CAL. BUS. & PROF. CODE § 4036).

25. *Id.* §§ 1, 2 (codified at CAL. BUS. & PROF. CODE §§ 2725.1, 3502.1).

26. Since the legislature did not clearly express its intention to provide a flexible approach, the approach adopted may have been fortuitous. Nevertheless, rigid approaches do not take into account the constant flow of new health care procedures and concepts or the need for the most effective utilization of allied health practitioners. The apparent flexible supervision formula of A.B. 717 will enable physician's assistants and nurse practitioners to utilize their training and experience fully and to function in areas geographically separated from the supervising physician. "The danger is that strict prior controls may become rigid, thus unduly limiting expanded medical delegation." Kissam, *Physician's Assistant and Nurse Practitioner Laws for Expanded Medical Delegation*, in *THE NEW HEALTH PROFESSIONALS* 125 (1977).

before the legal ramifications of the legislation can be ascertained.

A. Physical Presence or Something Less?

The language of the law suggests that the physical presence of the supervising physician is not required. The term "general supervision" is a retreat from the former restrictive approach to *physician's assistant* supervision in California.²⁷ Whether the new language allows supervision of allied health practitioners via direct communications, either by telephone, radio, or telecommunications, remains an open question.²⁸ But such a communications system is consistent with the purpose of A.B. 717 because it would enable more people in medically underserved areas to receive adequate health care. With the employment of such communications, allied health practitioners can work at great distances from the physician and exercise independent judgment relating to treatment while remaining legally "dependent" because their actions are subject to medical review and direction.²⁹ While the ultimate interpretation of "general supervision" remains for the future legislative or judicial determination, the term seems to indicate a reasonableness standard to help meet the goal of both quality and accessibility of health care services.

*B. Critical Evaluation: Who Has Ultimate Legal Responsibility³⁰
Under the Terms of the Legislation?*

1. Respondeat Superior

The framework instituted by the legislature for the more extensive use of allied health care personnel raises the question of who has ultimate

27. In California, the level and type of requisite physician's assistant supervision has been outlined by the state administrative agency that must approve physician's assistants, and not the legislature. Compare CAL. ADMIN. CODE tit. 16, § 1379.22 (1972) (very restrictive approach regarding physician assistant supervision) with CAL. ADMIN. CODE tit. 16, § 1379.22 (1977) (modifying the earlier supervision requirement). The question therefore remains open as to whether the legislature, in A.B. 717, has dictated a similar supervisory arrangement for *both* of the allied health practitioners. To answer this question, a clarification of the supervision requirement must come from the legislature and/or the courts.

28. The Michigan Physician's Assistants Act has adopted a definition of supervision which allows communication by telephone, radio, or telecommunications. Physician's Assistants Act, MICH. COMP. LAWS § 338.1952(k)(i) (MICH. STAT. ANN. § 14.718(12)(k)(i) (Callaghan 1977)). See CAL. ADMIN. CODE tit. 16, § 1379.22 (1977) (allowing electronic supervision of physician's assistants).

29. See generally Cohen & Dean, *To Practice or Not to Practice: Developing State Law and Policy on Physician Assistants*, 52 MILBANK MEMORIAL FUND Q. 349, 363-67 (1974).

30. Since the allied health practitioners engage in the primary care of patients, including recommending and giving treatments to patients, they will have certain legal respon-

responsibility for the patient's care.³¹ Established rules impose legal liability upon a physician for patient injuries caused by the conduct of subordinates.³²

Under the doctrine of respondeat superior, the employer is liable for the acts of his employees or agents.³³ When this doctrine is applied in health care situations, the physician has primary responsibility for the physician's assistant or nurse practitioner he employs. The employee, however, is also liable.³⁴ Therefore, a patient who suffers injury because of the negligence of an allied health practitioner has recourse against both the physician and the allied practitioner, and may sue either or both for damages.³⁵ The physician is ultimately responsible because while he delegates to the allied health practitioner certain aspects of the prescribed treatment, he retains control and supervision, thereby establishing a principal-agent relationship.³⁶

An employer may temporarily lend his employees to a third person. To find liability under respondeat superior when such a relationship exists, it must be determined who the employer was at the time of the negligent act. This depends on who had the right at the time to control and direct the allied health practitioner employee. If the power of direction and control lay with the temporary or special employer, he becomes responsi-

sibilities. See text accompanying notes 75-78 *infra*. This section of the comment confines itself to the question of who will have the ultimate legal responsibility under the terms of the legislation.

31. Law of Sept. 15, 1977, ch. 843, §§ 1-25, [1977] Cal. Stats. ____ (codified in scattered sections of CAL. BUS. & PROF. CODE and CAL. HEALTH & SAFETY CODE). Compensation of those injured is an important policy consideration; the basis of vicarious liability is one of policy. 1 D. LOISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 16.01, at 488 (1973).

32. 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 162 (1972).

33. *Gist v. French*, 136 Cal. App. 2d 247, 265, 288 P.2d 1003, 1014 (1955), *disapproved on other grounds*, *West v. City of San Diego*, 54 Cal. 2d 469, 478, 353 P.2d 929, 934, 6 Cal. Rptr. 289, 294 (1960), and *Deshotel v. Atchison, T. & S.F. Ry.*, 50 Cal. 2d 664, 667, 328 P.2d 449, 451 (1958); RESTATEMENT (SECOND) OF AGENCY § 219(1) (1958); *Sagall & Reed, Legal Responsibility for Negligence of Assistants, Substitutes, Partners, Consultants, and Jointly Treating Physicians*, in *MEDICINE, LAW AND PUBLIC POLICY* 218 (1975).

34. Allied health practitioners are vulnerable to lawsuits under the rule that an employee, agent, or servant is always responsible for his own torts, whether his employer is liable or not. *Bayuk v. Edson*, 236 Cal. App. 2d 309, 320, 46 Cal. Rptr. 49, 56 (1965).

35. W. SELL, *AGENCY* 83 (1975); RESTATEMENT (SECOND) OF AGENCY § 217B (1958).

36. For a discussion of the liability of principals for an agent's torts see W. SELL, *AGENCY* 95 (1975). The true test of whether the relationship of principal and agent exists is whether the physician actually exercises supervision and control over the allied health practitioner during the time he uses his services. *Id.* at 15; 2 F. HARPER & F. JAMES, *TORTS* 1366 (1956). Other reasons for attaching the ultimate responsibility to the supervising physician are compensation to the victims and loss spreading. Note, *Tort Liability and the California Health Care Assistant*, 45 S. CAL. L. REV. 768, 786 (1972) [hereinafter cited as *Tort Liability*].

ble for the negligence of the employee.³⁷ For example, a physician may lend the service of a nurse employee to another for a brief period of time and for a specified service. In such a case, the individual who directs the nurse will be responsible for his negligent acts while that individual exercises actual supervision over him.³⁸

2. Employee or Independent Contractor?

Since the doctrine of respondeat superior is applicable only when an employer-employee relationship exists, the pivotal issue in determining whether a physician will be liable for the negligence of an allied health practitioner is whether the negligent person may be considered an employee or an independent contractor. If the allied health practitioner is an independent contractor³⁹ or independent professional rather than an agent or employee, the supervising physician may not be liable for conduct of the allied health practitioner when carried out independently and not under his supervision or control.⁴⁰

In order to determine the character of an allied health practitioner's employment at the time of a negligent act, attention should be focused on whether he was acting as an agent, employee, or servant of the physician or was at that time outside the supervision and control of the physician. In California, physician's assistants are legally dependent on their supervising physicians. Thus, they fall squarely within the parameters of a principal-agent relationship.

As there is little difference in the duties performed by a physician's

37. *Deorosan v. Haslett Warehouse Co.*, 165 Cal. App. 2d 599, 604, 332 P.2d 422, 425 (1958); *Lowell v. Harris*, 24 Cal. App. 2d 70, 76-77, 74 P.2d 551, 555-56 (1938); *St. Paul-Mercury Indem. Co. v. St. Joseph's Hosp.*, 212 Minn. 558, 560, 4 N.W.2d 637, 638 (1942); RESTATEMENT (SECOND) OF AGENCY § 227, Comment a (1958).

38. *Cf. Synnott v. Midway Hosp.*, 287 Minn. 270, 178 N.W.2d 211 (1970) (nurse held to be borrowed servant of surgeon insofar as his services related to work controlled, directed, and supervised by surgeon).

39. Generally, an independent contractor is a person who, while exercising an independent employment, contracts to do work according to his own methods and without the control of the employer, except as to the result of the work. *Donroy, Ltd. v. United States*, 301 F.2d 200, 206 (9th Cir. 1962). Recent legislative trends, such as A.B. 717 and Michigan's new Physician's Assistants Act, MICH. COMP. LAWS §§ 338.1951-.1978 (MICH. STAT. ANN. §§ 14.718(11)-(38) (Callaghan 1977)), may permit physician's assistants and nurse practitioners to enter into limited independent practices in primary care. This, as the above definition suggests, does not necessarily make them independent contractors. In *Green v. Soule*, 145 Cal. 96, 78 P. 337 (1904), the court said: "The chief consideration which determines one to be an independent contractor is the fact that the employer has no right of control as to the mode of doing the work contracted for." *Id.* at 99, 78 P. at 339. As to independent contractors generally, see 38 CAL. JUR. 3D *Independent Contractors* §§ 1-28 (1977).

40. See 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 16.03, at 491 (1973); RESTATEMENT (SECOND) OF AGENCY § 250, Comment a (1958).

assistant and a nurse practitioner,⁴¹ arguably the same legal problems confront both groups. However, the nurse practitioners oppose being associated with the physician's assistants. They maintain that by definition, the physician's assistant is a physician-dependent health care worker, always working under the supervision, direct or indirect, of a physician. They make the point that, while physician's assistants are ostensibly in every case subordinate to a supervising physician,⁴² nurse practitioners derive their authorization to practice from the state's Nursing Practice Act⁴³ and may therefore practice independently.⁴⁴

Since nurse practitioners insist on occupational independence, and since it can be argued that their relationships conform to the criteria for independent contractors,⁴⁵ separate attention will here be given to those practitioners.

3. Can the Nurse Practitioner Truly Be an Independent Professional— Not Under the Control of the Physician?

Considerable research has recently been conducted on the increased utilization of nurse practitioners to provide health care on a more equitable basis.⁴⁶ Current efforts are designed to utilize nurse practitioners in physician-deprived primary health care areas⁴⁷ where they can make

41. Andrus & Fenley, *Assistants to Primary Physicians in California*, 122 W.J. MED. 80, 81 (1975). See also Glenn & Goldman, *Task Delegations to Physician Extenders—Some Comparisons*, 66 AM. J. PUB. HEALTH 64 (1976). The latter article examines the delegation of tasks to physician's assistants and nurse practitioners to determine the impact on productivity, finding no distinction between delegation patterns for nurse practitioners and physician's assistants.

42. H. CREIGHTON, *CHANGING LEGAL ATTITUDES: THE EFFECT OF THE LAW ON NURSING* 13-14 (1974); Mauksch, *Nursing Is Coming of Age Through the Practitioner Movement: Pro*, 75 AM. J. NURSING 1834, 1842 (1975).

43. CAL. BUS. & PROF. CODE §§ 2700-2830 (West 1974 & Supp. 1978).

44. See E. COHEN, L. CROTOF, M. GOLDFARB, K. KEENAN, M. KORPER, & M. TRIFFIN, *AN EVALUATION OF POLICY RELATED RESEARCH ON NEW AND EXPANDED ROLES OF HEALTH WORKERS* 33-34 (1974); Rothberg, *Nurse and Physician's Assistant: Issues and Relationships*, 21 NURSING OUTLOOK 154 (1973). See also A. FORD, *THE PHYSICIAN'S ASSISTANT* 45 (1975).

45. I. MURCHISON & T. NICHOLS, *LEGAL FOUNDATIONS OF NURSING PRACTICE* 247-48 (1970).

46. See generally V. HALL, *STATUTORY REGULATION OF THE SCOPE OF NURSING PRACTICE—A CRITICAL SURVEY* (1975); H. SULTZ, M. ZIELEZNY, & L. KINYON, *LONGITUDINAL STUDY OF NURSE PRACTITIONERS* (1976); Bullough, *The Law and the Expanding Nursing Role*, 66 AM. J. PUB. HEALTH 249 (1976); Mauksch, *Nursing Is Coming of Age Through the Practitioner Movement: Pro*, 75 AM. J. NURSING 1834, 1842 (1975); Mereness, *Recent Trends in Expanding Roles of the Nurse*, 18 NURSING OUTLOOK 30 (1970).

47. "The Legislature . . . finds that encouraging the training of primary care . . . nurse practitioners will assist in making primary health care services more accessible to the citizenry, and will, in conjunction with the training of family physicians, lead to an

independent clinical decisions⁴⁸ at first contact with patients before they reach a doctor. Paradoxically, although the nurse practitioner is taking on expanded responsibilities for patient care, the overlapping of his role with medicine places him under the authority of the physician,⁴⁹ while the term nurse *practitioner* suggests that the nurse is not subject to another's discretion or authority but may practice independently. The chief question, then, is whether nurse practitioners are legally "dependent" on the physician, as their actions are subject to medical review and direction, or whether they are legally independent.⁵⁰

There is no requirement that a nurse practitioner be an employee of a physician.⁵¹ The Nursing Practice Act, for example, states merely that "[i]t is the legislative intent . . . to permit additional sharing of functions within organized health care systems which provide for collaboration between physicians and registered nurses."⁵² While there is no further clarification of the word "collaboration," the clause constitutes statutory recognition that medicine and nursing are distinct professions with regard to their independent practice, but that the functions of the two overlap.⁵³ Thus, a nurse practitioner's legal relationship to his supervising physician may be that of an independent contractor as opposed to that

improved health care delivery system in California." CAL. EDUC. CODE § 31910 (West 1976).

48. They are independent in that it is the nurse practitioner who can assess a patient's medical condition, recommend and administer a specific treatment, decide that no intervention other than reassurance is needed, or refer the patient to a physician. California Joint Practice Commission Statement on Family Nurse Practitioners in Primary Care 2 (unpublished Commission Statement approved by the California Joint Practice Commission on October 18, 1975) (discussion of primary care and the assumption of responsibility in primary care by nurse practitioners).

49. The nursing profession argues that for many years nurses in remote areas lacking nearby physicians have functioned effectively as primary health providers, treating injury and illness and arranging medical attention whenever situations have warranted it. See Rogers, *Nursing Is Coming of Age Through the Practitioner Movement: Con*, 75 AM. J. NURSING 1834, 1835 (1975).

50. The argument currently expounded by many in the nursing profession that nurse practitioners are legally independent could be a sign of a movement away from the traditional nursing model that reinforces physician responsibility and nurse subordination.

51. A search of the California codes and regulations dealing with classes of nurse practitioners failed to reveal such a requirement.

52. CAL. BUS. & PROF. CODE § 2725 (West Supp. 1978). Note that if the physician is ultimately responsible, he is the final authority and does not function solely in a "collaborative" role.

53. V. HALL, STATUTORY REGULATION OF THE SCOPE OF NURSING PRACTICE—A CRITICAL SURVEY 26 (1975). Because of agency theories which rebut the argument that allied health practitioner employees are independent of physician responsibility, the supervising physician will continue to be a target for malpractice suits. See authorities cited note 33 *supra*.

of an employee.⁵⁴ If this is indeed the case, the nurse practitioner's supervising physician would be immune from vicarious liability for the acts of his independent contractor.⁵⁵ Unless, however, the role evolves in a manner that provides a higher degree of professional autonomy, nurse practitioners will not be considered independent contractors.⁵⁶

In spite of the arguments of the nursing profession, the language of A.B. 717 with regard to supervision provides that both nurse practitioners and physician's assistants are to function in a dependent or agency relationship with the supervising physician.⁵⁷ A relationship of this type suggests that the supervising physician must assume responsibility for the proper supervision of the allied health practitioner.⁵⁸ Neither of the two types of allied health practitioners can be totally independent because the bill provides that the physician must maintain general supervision.⁵⁹ This indicates that nurse practitioners and physician's assistants are dependent upon and accountable to the physician, as they are now entering an area that has previously been defined as medical care. If a physician's assistant or nurse practitioner were to dispense, administer, or prescribe drugs or devices without the general supervision of a licensed physician, then the physician's assistant or nurse practitioner would be practicing medicine in violation of the law.⁶⁰

54. Also, it may be argued that the term "general supervision," as employed in A.B. 717, would enable nurse practitioners to act as independent contractors. A similar argument has been made by a dental hygienist in California who separated herself from a dentist employer and established her own office. Siegel, *Dental Hygienist Braces for Legal Test*, L.A. Times, Oct. 3, 1977, pt. 4, at 1, col. 4 [hereinafter cited as L.A. Times]. The legislature had enacted a new law controlling dental auxiliaries, CAL. BUS. & PROF. CODE §§ 1740-1767 (West Supp. 1978), which expanded the role of dental hygienists and assistants, permitting them to work under the "general supervision" of a dentist. *Id.* §§ 1757, 1759. Prior law apparently required direct supervision. *Id.* § 1746 (West 1974). Linda Krol and others interpreted the new language as permitting hygienists to "work in their own office[s]." L.A. Times, *supra*, at 8, col. 1. Krol was formally charged with practicing in a place not under the control of a dentist. Legal uncertainties arise due to disagreement over terms such as "general supervision," which are still unclear since Krol is the first hygienist to be formally charged under the new law. The same analysis may be applied to nurse practitioners.

55. See 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 16.03, at 491 (1973); *RESTATEMENT (SECOND) OF AGENCY* § 250, Comment a (1958).

56. See text accompanying notes 57-60 *infra*.

57. See Cohen & Dean, *To Practice or Not to Practice: Developing State Law and Policy on Physician Assistants*, 52 *MILBANK MEMORIAL FUND Q.* 349, 363 (1974) (referring to physician's assistants but by implication including nurse practitioners).

58. See note 33 *supra*.

59. Law of Sept. 15, 1977, ch. 843, §§ 1, 2, [1977] Cal. Stats. ____ (codified at CAL. BUS. & PROF. CODE §§ 2725.1, 3502.1). If a nurse practitioner or physician's assistant simply executes legal medical standing orders, his function is a dependent one, since his performance is contingent upon physician supervision or direction.

60. See text and authorities accompanying note 23 *supra*.

4. Additional Physician Liability

In addition to incurring vicarious liability based upon the respondeat superior doctrine, the physician may be directly liable if he is found to have been negligent in the manner in which he used his assistant.⁶¹ Negligence of this type could consist of the physician's failure to exercise the requisite skill and care in supervising his assistant.⁶² A physician may also be culpable if he did not exercise proper care in delegating to an assistant a task that he knew, or should have known, to be beyond the assistant's competence, even if the assistant performed it to the best of his ability.⁶³ It is assumed that the physician is in the best position to know the extent of the allied health practitioner's competence.⁶⁴ Finally, it must be noted that the physician has an obligation to employ due care in the selection of his assistants.⁶⁵

III. WILL THE POTENTIAL THREAT OF MALPRACTICE SUITS DETER THE UTILIZATION OF ALLIED HEALTH PRACTITIONERS?

As allied health practitioners undertake greater responsibilities, the range of potential error attributable to this mode of providing health care and the concomitant expanded tort liability could seriously impair effective use of these health care providers.⁶⁶ It is possible that the risks of potential physician liability for the negligent acts of allied health practitioners under the respondeat superior doctrine may deter employment of allied health practitioners.⁶⁷

In discussions with members of both the legal and medical professions who are acutely aware of the current malpractice crisis, the author has found that many physicians in California are anxious about the use of allied health practitioners because as supervising physicians they retain the legal responsibility and liability for the acts of their assistants. This apprehension has been fueled by the uncertainties of malpractice insurance coverage. The costs of malpractice insurance in the last few years have risen greatly.⁶⁸ Furthermore, uniform standards for malpractice

61. *See Tort Liability, supra* note 36, at 777-79.

62. *Id.* at 777 & n.44.

63. *See id.* at 777.

64. Cohen & Dean, *To Practice or Not to Practice: Developing State Law and Policy on Physician Assistants*, 52 MILBANK MEMORIAL FUND Q. 349, 361 (1974).

65. *Tort Liability, supra* note 36, at 777 & nn.41 & 42.

66. *Id.* at 780-84.

67. *Id.* at 781-82 (doctrine of respondeat superior creates a substantial hindrance to health care assistant utilization).

68. *See Rubsamen, Medical Malpractice*, 235 SCIENTIFIC AM. 18, 22-23 (1976). The dramatic rise in the costs of malpractice coverage was fueled by the number of claims

insurance for physicians supervising allied health practitioners have not been established.⁶⁹ Provisions for allied health practitioners vary among different insurance companies.⁷⁰

It should be noted that the risk factors discussed herein may be perceived by physicians as more critical than they really are. As of this writing, the author knows of no malpractice suits brought in California against either nurse practitioners or physician's assistants, or against physicians operating in their supervisory capacities. The probable reason for the absence of such suits is that physicians who employ these new health practitioners tend to be conservative initially. Under the threat of legal liability the physician will employ only qualified assistants⁷¹ and will likely maintain close supervision. As confidence grows between the physician and his assistant, the form of supervision will undoubtedly be modified. By delineating the functions between himself and his "extender," the physician should be able to protect himself.⁷² In addition, malpractice coverage for allied health practitioners seems to be a comparatively minor cost of employing an allied health practitioner in California.⁷³ With these factors in mind, the physician should not be discouraged from using allied health practitioners by the potential legal

filed. In California the number of malpractice claims filed rose from 13.5 per 100 physicians in 1965 to more than 18 per 100 physicians in 1974. CAL. ASSEMBLY SELECT COMM. ON MEDICAL MALPRACTICE, PRELIMINARY REPORT (1974), reprinted in Waxman, *Spiraling Costs: A Health Care Slide*, 11 TRIAL 23, 23 (1975).

69. Oseran, *Physician's Assistants in California*, 124 W.J. MED. 258, 262 (1976).

70. *Id.* Several insurance companies have extended physicians' policies to cover allied health practitioners. One California underwriter of liability insurance for physicians has been successfully insuring physicians who employ allied health practitioners, and charges about \$84 to \$100 per year. K. Cheitlin & M. Grisham, *Reimbursement for Mid-Level Practitioners: A Strategy for Increasing Health Care Efficiency* 36 (Aug. 2, 1977) (unpublished Governor's Intern Report in Office of Health Professions Development, Cal. Dep't of Health, Sacramento, California).

71. In addition to legislative sanction, the fact that physician's assistants and nurse practitioners must be graduates of approved programs allows the prospective employer to presume that the allied health practitioner is qualified. Nurse practitioners are licensed registered nurses who have already been subject to a standardized curriculum. See CALIFORNIA HEALTH MANPOWER REPORT, *supra* note 1, at 25. Regarding physician's assistants, the California Administrative Code provides: "[N]o person shall be approved to practice as a physician's assistant in this state without having successfully completed the primary care physician's assistant examination of the National Commission on Certification of Physician's Assistants." CAL. ADMIN. CODE tit. 16, § 1379.12 (1977).

72. In this way, the allied health practitioner would be using a variant of the standardized protocol, currently in use by nurse practitioners, in order to structure responsibilities. On standardized protocols in regard to nursing practice, see CAL. BUS. & PROF. CODE § 2725(d) (West Supp. 1978). The protocols permit physicians to limit the amount of discretion exercised by an assistant to whom some elements of the practice of medicine are delegated.

73. See note 70 *supra*.

consequences resulting from the doctrine of respondeat superior. In fact, there remain many incentives for physicians to employ allied health practitioners, including increased net income, expanded patient care, and increased control over working hours.⁷⁴

IV. LIABILITY OF ALLIED HEALTH PRACTITIONERS

Since allied health practitioners will be assuming wide responsibilities in primary care, which is first-contact medicine, there are various points at which civil liability can arise. In such an environment, and under the provisions of A.B. 717, allied health practitioners will have some discretion in the various medications, drugs, or devices that they can use. If they choose the wrong one, or the wrong dosage in the case of drugs, and injury results to the patient, they can be held liable.⁷⁵ Essential to their role as primary health care providers is the concept of accountability to the patient.⁷⁶ The allied health practitioners must recognize and fulfill competently their responsibilities for the care of patients.⁷⁷

Neither nurse practitioners nor physician's assistants are immune to lawsuits or legal responsibilities.⁷⁸ Because of the independence incident to their expanded roles, they can no longer rely solely upon the decisions of their supervising physicians. The lawyer, in evaluating legal responsibility, should note the share of medical responsibility taken by the allied health practitioner. With the increase in responsibility, there is an attendant increase in the exposure to civil liability.

A. *Allied Health Practitioner Standard of Care*

Any examination of problems of medico-legal liability must include a discussion of what standard of care the allied health practitioner must meet. However, since the allied health occupations are so novel, and their practitioners are provided with opportunities to work in such varied medical settings,⁷⁹ it is difficult to determine what standards have been

74. Glenn & Hofmeister, *Will Physicians Rush Out and Get Physician Extenders?*, 11 HEALTH SERVICES RESEARCH 69, 70 (1976).

75. *See Hallinan v. Prindle*, 17 Cal. App. 2d 656, 62 P.2d 1075 (1936).

76. *See generally* Abdallah, *Nurse Practitioners and Nursing Practice*, 66 AM. J. PUB. HEALTH 245, 245 (1976).

77. In performance of his professional duties, an allied health provider will necessarily be required to exercise reasonable care to see that no unnecessary harm comes to the patient. *See* the discussion of the allied health practitioner's standard of care in text accompanying notes 79-86 *infra*.

78. *See* notes 34-35 *supra* and accompanying text.

79. A few of the medical settings within which allied health practitioners can work are physicians' offices, clinics, health centers, industries, homes, schools, and acute care facilities. California Joint Practice Commission Statement on Family Nurse Practitioners

established in practice. In addition, there is a lack of legal precedent specifically involving these allied health practitioners. It is therefore not clear by what standard of care they will be judged.⁸⁰

Further, although A.B. 717 appears to promote similarity of function between nurse practitioners and physician's assistants in the dispensation, prescription, and administration of drugs or devices, specialization exists within each of the allied health occupations.⁸¹ Within both of the occupations, individual practitioners perform different tasks at different levels.⁸²

Still, to succeed in court, an injured patient must show that the allied health practitioner failed to live up to a required standard of care. Since the functions to be performed by the allied health practitioners under A.B. 717 involve the exercise of a special skill, the usual standard, what a reasonable person would do in similar circumstances, would probably not be applied. Because a physician's assistant or nurse practitioner⁸³ would be performing functions that have previously been within the exclusive sphere of a physician's medical practice, the standards to which physicians are held would likely be applied.⁸⁴ The California

in Primary Care 4 (unpublished Commission Statement approved by the California Joint Practice Commission on October 18, 1975) (referring to family nurse practitioners but by implication including allied health practitioners).

80. The California Health & Safety Code establishes the standard of care of trainees, including nurse practitioners and physician's assistants, in Health Manpower Pilot Projects: "A trainee and his supervisor shall be held to the standard of care of an individual otherwise legally qualified to perform the health care service or services performed by such trainee or supervisor." CAL. HEALTH & SAFETY CODE § 429.74 (West Supp. 1978). However, this code section has not been interpreted by the courts. In addition, the statutory language is ambiguous as to whether allied health practitioners must conform to the standards of acceptable practice for the supervising physician or must only meet the standard of care of a legally qualified allied health practitioner. Such ambiguity furnishes no assistance in forecasting how the courts will hold with regard to the standard of care required of allied health practitioners.

81. See, e.g., CAL. ADMIN. CODE tit. 16, §§ 1379.40-.86 (1977), which outlines the specialty levels of physician's assistants in California. They are (1) orthopedic physician's assistant, (2) emergency care physician's assistant, (3) allergy physician's assistant, and (4) specialist physician's assistant. *Id.*

82. Differences in practice settings require that personnel with the same general background perform in vastly different ways. The uses of the allied health practitioners are as varied as the types of practice settings. See note 79 *supra*.

83. There is no indication whether "the reasonable nurse practitioner" is a general standard or one more specifically delimited by a consideration of the level of nursing proficiency. See generally Note, *The Negligent Nurse: Rx for the Medical Malpractice Victim*, 12 TULSA L.J. 104 (1976).

84. Where an individual undertakes to practice medicine, he is held to the standard of care of a physician. Cf. *Hendry v. United States*, 418 F.2d 774, 784 (2d Cir. 1969) (doctor practicing without a license held to the standard of care of a qualified licensed practitioner). Although this case was based on New York law, it is often cited for the above-mentioned general principle.

courts will probably advance a proposition similar to one suggested here by the author: allied health practitioners, when they perform procedures which have been considered as within the sole province of medical practice, must possess and exercise in diagnosis and treatment that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by medical practitioners under similar circumstances.⁸⁵ Thus, where an allied health practitioner enters into an area traditionally characterized as medical care, the courts will find it reasonable to hold the allied health practitioner to a physician's standard of care.⁸⁶

B. Liability for Unauthorized Treatment—Lack of Informed Consent

An injured patient has a cause of action against an allied health practitioner for treatment, including the administration, dispensation, and prescription of drugs or devices,⁸⁷ to which he did not consent. Traditionally, the doctrine of informed consent has been applied to the physician-patient relationship.⁸⁸ However, with new medical responsibilities being delegated to allied health practitioners, it is easy to foresee an extension of that doctrine to the allied health practitioner-patient relationship.

The requirement of informed consent to medical procedures has always been recognized as a key element in the medical practitioner-patient relationship.⁸⁹ Legal liability is imposed not because the treatment was

85. This proposition was developed by the author by extrapolating the present standard of care in California for physicians to allied health practitioners. The California courts require only that "physicians and surgeons exercise in diagnosis and treatment that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." *Sinz v. Owens*, 33 Cal. 2d 749, 753, 205 P.2d 3, 5 (1949); *Carmichael v. Reitz*, 17 Cal. App. 3d 958, 975, 95 Cal. Rptr. 381, 390 (1971).

86. It seems both reasonable and logical that when a task that is ordinarily performed by a physician is performed by a nonphysician, the latter would be held to the physician's higher standard of care. See note 84 *supra*.

87. The use of drugs is a distinct type of treatment. See *STEDMAN'S MEDICAL DICTIONARY* 1066 (4th Law. ed. 1976) (defining "pharmacotherapy").

88. See *Beloud*, *The Growing Importance of Informed Consent*, 13 CAL. TRIAL LAW. A.J. 39 (1973-74).

89. Horan, *Authority for Medical Treatment: Consent*, in *MEDICAL MALPRACTICE* ¶7.2 (Ill. Inst. for Continuing Legal Educ. 1975). See also D. HARNEY, *MEDICAL MALPRACTICE* § 2.4 (1973) [hereinafter cited as HARNEY]; A. HOLDER, *MEDICAL MALPRACTICE LAW* 225 (1975); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U.L. REV. 628 (1970). An exception to the requirement of informed consent arises in emergency situations. HARNEY, *supra*, § 2.3(B). If the treating practitioner is confronted with a person whose medical condition is so critical as to demand immediate care or treatment to protect his life or health, an emergency exists upon which that practitioner may rely as a justification for treating the person without first obtaining the normally required consent. See *Wheeler v. Barker*, 92 Cal. App. 2d 776, 781, 208 P.2d 68, 71 (1949); CAL. ADMIN.

rendered in a negligent manner but because the patient's legally protected interest was invaded without his consent.⁹⁰ Usually, the protected legal interest is bodily integrity, and unauthorized invasion of that interest is technically a battery.⁹¹ The rule imposing liability for battery is applicable even where consent is given if such consent is not informed or knowledgeable,⁹² or if a substantially different treatment from that for which consent was obtained is performed.⁹³ In addition to the lawsuits founded on battery, many of the actions alleging lack of informed consent are brought upon a theory of negligence.⁹⁴ In the suits founded on negligence, the argument is made that the medical practitioner who fails to properly inform his patient of the procedure to be performed has failed to meet his duty of care.⁹⁵

The standard and scope of the consent has been left to judicial determination.⁹⁶ The California courts have developed the proposition that if a medical practitioner—and probably also an allied health practitioner—withholds any facts which are necessary to form the basis of an intelligent and informed consent, the practitioner opens himself to liability.⁹⁷ The California Supreme Court has held that the duty to disclose such facts is imposed by law because of the fiduciary relationship between medical

CODE tit. 16, § 1379.2 (1977) (a patient's informed consent must be obtained by a physician's assistant except for emergency services).

90. *Berkey v. Anderson*, 1 Cal. App. 3d 790, 803, 82 Cal. Rptr. 67, 76-77 (1969). A medical practitioner is accountable for any injury resulting from unauthorized treatment even though it was skillfully performed. *Id.*

91. *Pedesty v. Bleiberg*, 251 Cal. App. 2d 119, 124, 59 Cal. Rptr. 294, 298 (1967); *Weinstock v. Eissler*, 224 Cal. App. 2d 212, 233, 36 Cal. Rptr. 537, 551 (1964); W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 9 (4th ed. 1971).

92. *Berkey v. Anderson*, 1 Cal. App. 3d 790, 803, 82 Cal. Rptr. 67, 76-77 (1969).

93. *Cobbs v. Grant*, 8 Cal. 3d 229, 239, 502 P.2d 1, 7, 104 Cal. Rptr. 505, 511 (1972).

94. "[W]hen an undisclosed potential complication results . . . , the courts are divided on the issue of whether this should be deemed to be a battery or negligence." *Id.*

95. *See id.* at 240-41, 502 P.2d at 8, 104 Cal. Rptr. at 512. *See also* Beloud, *The Growing Importance of Informed Consent*, 13 CAL. TRIAL LAW. A.J. 39 (1973-74).

96. For a good treatment of consent requirements and the standards enunciated by the California courts, see E. WALLACH & W. BOONE, CALIFORNIA TORT GUIDE §§ 8.8-.9 (Cal. Continuing Educ. Bar Prac. Book No. 50, 1971 & Supp. 1975).

97. *Berkey v. Anderson*, 1 Cal. App. 3d 790, 804, 82 Cal. Rptr. 67, 77 (1969). Note that the person giving the consent must himself have the legal capacity to do so. For this reason the law provides that in an emergency situation consent is implied, *Wheeler v. Barker*, 92 Cal. App. 2d 776, 781, 208 P.2d 68, 71 (1949), and if the patient is a minor or incompetent the prerogative to consent is transferred to the patient's closest available relative or legal guardian. *Cobbs v. Grant*, 8 Cal. 3d 229, 244, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972). In all other cases, the patient's consent must result from a decision reached after his consideration of the risks and consequences which the medical or health care practitioner has explained. *See* Kessenick & Mankin, *Medical Malpractice: The Right to Be Informed*, 8 U.S.F. L. REV. 261 (1973).

practitioner and patient.⁹⁸ The court held further that when a procedure inherently involves a known potential for death or serious bodily harm, it is the medical practitioner's absolute duty to inform the patient of the possibility of such a consequence and to describe in lay terms the potential complications.⁹⁹ Where the possibility of death or serious bodily harm from the procedure is not great, the medical practitioner has a duty to disclose only such risks as a skilled practitioner of good standing would provide under the circumstances.¹⁰⁰ But there is no duty to discuss the comparatively minor risks inherent in common procedures, when such procedures seldom have serious results.¹⁰¹ Even with the guidelines enunciated by the courts, there will remain the question of just how much information a medical or health care practitioner may have to disclose before obtaining consent to a medical procedure.¹⁰²

Although the issue is not often litigated, a physician who prescribes drugs must obtain informed consent.¹⁰³ Again, the standards applied to the physician in this case will likely be attached to the physician-extending allied health practitioner. Since the allied health practitioners will be in the best position to present the necessary warnings to the patient, the courts will probably impose an obligation to convey the information to the patient.¹⁰⁴

Another problem in the area of informed consent is that a patient might consent to a treatment rendered by an allied health practitioner under a false assumption about the identity of the practitioner.¹⁰⁵ Whether the false assumption results from misrepresentation, misperception, or omis-

98. *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 9-10, 104 Cal. Rptr. 505, 513-14 (1972).

99. *Id.* at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.

100. *Id.* at 244-45, 502 P.2d at 11, 104 Cal. Rptr. at 515.

101. *Id.* at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.

102. The supreme court notes that "[t]he scope of the disclosure required of physicians defies simple definition." *Id.* at 244, 502 P.2d at 10, 104 Cal. Rptr. at 514.

103. *Zaslow, Informed Consent in Medical Practice*, 22 THE PRAC. LAW. 13, 22 (1976).

104. *Id.* at 23 (referring to physicians but by implication including allied health practitioners). See *Love v. Wolf*, 226 Cal. App. 2d 378, 38 Cal. Rptr. 183 (1964), where the court held that prescription drug warnings from a drug manufacturer need only go to the physician. "[I]f adequate warning of potential dangers of a drug has been given to doctors, there is no duty by the drug manufacturer to insure that the warning reaches the doctor's patient for whom the drug is prescribed." *Id.* at 395, 38 Cal. Rptr. at 193.

105. Such a legal consideration clearly prompted the adoption of § 1379.28 of the California Administrative Code, which requires that "[w]hen rendering medical services, a physician's assistant shall at all times wear an identification badge on an outer garment and in plain view, which shall state the assistant's name and . . . title . . ." CAL. ADMIN. CODE tit. 16, § 1379.28 (1977). While working, nurse practitioners as well as physician's assistants should be clearly identified as such to avoid the likelihood that a patient may mistake them for physicians.

sion, the patient's consent is not "informed." In such a case, the allied health practitioner may incur liability for unauthorized treatment if the practitioner's tasks involved a touching of the patient's body, as when administering a drug or device.¹⁰⁶

With respect to the form of the consent, there is no legal requirement that the consent be in writing.¹⁰⁷ It need not even be expressed in words; in many cases it will be inferred from conduct.¹⁰⁸ Nevertheless, a physician's assistant or nurse practitioner would be unwise to assume that merely because a patient has consulted him about a medical complaint, the patient has impliedly consented to treatment for it. In many cases it would be desirable for the consent to be in writing.¹⁰⁹ With major procedures, it is particularly desirable for details to be included in a written form of consent.¹¹⁰

C. Liability for Failure to Refer

An alternative theory for allied health practitioner liability is failure to refer. When a patient avails himself of the services of an allied health practitioner, he has the right to expect the practitioner to be competent.¹¹¹ When the allied health practitioner encounters a problem beyond his competence, he has a duty to consult a physician¹¹² or refer his case to a physician.¹¹³

The primary care in rural and inner city settings provides the climate for the allied health practitioner to function independently in terms of the decisions he makes. This would include the determination of whether or

106. W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 9 (4th ed. 1971).

107. *Id.* § 18.

108. *Bradford v. Winter*, 215 Cal. App. 2d 448, 454, 30 Cal. Rptr. 243, 246 (1963); *Kritzer v. Citron*, 101 Cal. App. 2d 33, 38-39, 224 P.2d 808, 811 (1950).

109. "A patient will be presumed to have comprehended the nature, terms, and effect of a written consent to treatment." HARNEY, *supra* note 89, § 2.2(B).

110. This is so because the allied health practitioner would be represented by his records and could rely on the presumption that the patient has been properly informed. *See* note 109 *supra*.

111. In the case of a physician, the patient has the right to assume that the physician, if he is not competent, will refer him to those who are most properly qualified to attend his medical problem. *Batty v. Arizona State Dental Bd.*, 57 Ariz. 239, 254, 112 P.2d 870, 877 (1941). This duty will, in all likelihood, be extended to allied health practitioners.

112. It may also be necessary to determine if a specialist must be consulted. If the allied health practitioner failed to refer to or consult a specialist when he had a duty to do so, he would have to conform to the standard of the specialist. *See* text and cases cited in E. WALLACH & W. BOONE, CALIFORNIA TORT GUIDE § 8.3 (Cal. Continuing Educ. Bar Prac. Book No. 50, 1971 & Supp. 1975). Specialists, in turn, are held to higher standards than the general medical practitioner. *See* HARNEY, *supra* note 89, § 3.6.

113. *See Tort Liability*, *supra* note 36, at 776. *Cf. Sinz v. Owens*, 33 Cal. 2d 749, 758, 205 P.2d 3, 8 (1949) (jury instruction implying a duty to consult or refer).

not a patient's condition is within the practitioner's competence or requires referral.¹¹⁴ The allied health practitioner's duty is arguably fulfilled when he employs skills commensurate with his training, and refers or reports all needs beyond his competence to the supervising physician.

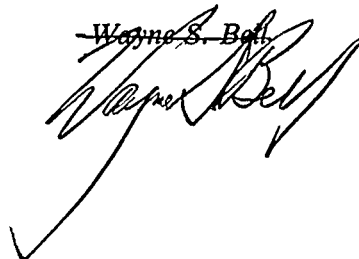
The duty to refer, as well as the other duties imposed upon allied health practitioners, is not an extraordinary imposition of tort liability upon these novel health care providers. It is applied on the assumption that both physician's assistants and nurse practitioners are governed by the same general principles of tort liability that apply to physicians.

V. CONCLUSION

Legislation in the field of health care services should be flexible enough to allow for the expanding and changing roles of the allied health occupations, while at the same time insuring patient safety. At stake is the viability of California's health care system.

If the past is a guide, definitive solutions to the current problems in this area will come slowly. Nevertheless, A.B. 717 is a response to the current need for improved medical and health care through an enlarged source of health manpower. It is a positive move toward alleviating the shortage of health care personnel in rural and inner city health care deficient areas. This legislation is flexible enough to permit the best use of the talents of allied health practitioners without complicated rules and regulations. The primary legal control will remain the law of malpractice. A.B. 717 will insure the legality of the allied health practitioner's performance while assuring that the patient's welfare is safeguarded.

The general impact of this recent legislative scheme was examined here to show the legal practitioner potential legal consequences. As society weighs the benefits received, the bringing of needed services into areas which otherwise would probably not be reached, against the costs of potential legal ramifications, the benefits will clearly tip the scales.

~~Wayne S. Bell~~


114. *Tort Liability*, *supra* note 36, at 776.