



# CONNECTICUT ACADEMY OF PHYSICIAN ASSISTANTS

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One Regency Drive • PO Box 30 • Bloomfield, CT 06002  
860/243-3977 • Fax: 860/286-0787 • [connapa@ssmgt.com](mailto:connapa@ssmgt.com) • [www.connapa.org](http://www.connapa.org)

**TESTIMONY by the  
Connecticut Academy of Physician Assistants  
For the Public Health Committee  
Raised SB 1202 – An Act Concerning the State’s Health Care Workforce**

**Wednesday, March 23, 2011**

The Connecticut Academy of Physician Assistants (ConnAPA) is the only professional society representing all physician assistants (PAs) in Connecticut. PAs are licensed healthcare professionals who practice medicine with physician supervision. We care for patients across the age continuum from pediatric to geriatric populations in primary care and in all medical and surgical specialties in all 50 states, the District of Columbia, Guam, the armed forces, and the federal services. The Academy serves as the collective voice for over 1600 PAs practicing in Connecticut (CT). A major component of our mission is to provide accessible, high quality, cost-effective healthcare to the CT residents we serve. We accomplish this by working in partnership with our supervising physician colleagues.

ConnAPA commends the members of the Public Health Committee for their efforts to increase both the access to and the quality of health care with SB 1202. To that end, we respectfully request that the Committee consider amending SB 1202 with language, which we believe would *further* improve the health care system in CT. Of note, we have attached current statute and suggested draft model language in the Appendices; but we will briefly describe our three goals and rationale below.

### **Ratio Restriction of PAs to Supervising Physicians**

The first area of improvement that we envision would increase access to care for patients in CT would be by deleting the ratio provision placed on the number of PAs that a physician can supervise. Currently, CT statute specifies that a physician may supervise a maximum of six PAs. A specific number should not be included in the law because decisions about the appropriate number of PAs that a physician can supervise simultaneously should be made at the practice level, where a multitude of factors unique to each practice will dictate the suitable ratio of PAs to a physician [i.e. types of medical services being provided, the training and experience of the PAs, the complexity of the patient population, and the supervisory approach of the supervising physician(s)]. Any number specified in state law may be too many PAs for some situations and too few PAs in other situations. Six may be an appropriate number in many clinical settings; but in a trauma surgery case it may be appropriate for a physician to supervise only one PA, although current law would allow six. On the other hand, if a physician at a well child clinic supervises six PAs during the week, and wants to hire two additional PAs to see patients every other Saturday, that physician would be prohibited from doing so according to current state law. Ideally, the language defining the ratio of PAs to a supervising physician should be deleted from statute and not determined by state-wide authorities but rather by each individual practice and each physician-PA team. The Medical Examining Board would still have full authority to discipline a physician who is improperly supervising PAs. ConnAPA is not the only organization that believes the

appropriate ratio should be determined at the practice level. The American Academy of Family Physicians (AAFP), the American Medical Association (AMA), the American Academy of Physician Assistants (AAPA), the American College of Physicians (ACP), and the Federation of State Medical Boards all have guidelines, policies, acts, or recommendations that either intentionally do not include a specific ratio or purposely state that the ratio should be determined at the practice level. For comparison's sake, eight states have no ratio restrictions, including nearby Rhode Island and Maine, along with Alaska, Arkansas, New Mexico, North Carolina, North Dakota, and Tennessee. For current statute and suggested model legislation, see [Appendix A](#). For more information on why the appropriate number of PAs should be determined at the practice level rather than in state law, see the Issue Brief in [Appendix B](#).

### **Supervision Language**

The second area of change in the health care system that ConnAPA believes would lead to more efficient, effective care of patients would be to modify the current supervision language. Current statute states that the supervising physician must do a personal review of the PA's practice at least weekly or more frequently as necessary to ensure quality patient care. The words "at least weekly or more frequently" should be deleted. Appropriate methods of supervision should be customizable by the supervising physician based on several factors which are unique to each practice, including the practice setting, the types of patient care seen in the practice, and the skills and experience of the PA(s). Requiring specific methods of supervision in state laws, such as weekly face-to-face meetings and requiring all charts to be reviewed within a certain time frame, uses a one-size-fits-all approach to physician-PA teams that work in extremely diverse practices. By putting the primary decision-making authority in the hands of the supervising physician, who is in the best position to determine which methods of supervision are most appropriate, physician-PA teams will be able to provide more efficient and effective patient care. Hospitals and other medical facilities would still have the authority to customize supervision methods for each PA. The physician community also supports this type of language, as can be seen in the "Guidelines for Physician/PA Practice", which were adopted by the AMA House of Delegates. These guidelines state that:

- The role of the PA in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the PA and based on the physician's delegatory style.
- The physician must be available for consultation with the PA at all times either in person or through telecommunication systems or other means.
- The physician is responsible for clarifying and familiarizing the PA with his supervising methods and style of delegating patient care.

Examples of states in our area that have adaptable supervision language in existing statute are Massachusetts, Maine, Maryland, New Hampshire, New York, and Rhode Island. Others areas are California, D.C., Hawaii, Michigan, Minnesota, North Dakota, South Dakota, Utah, and Wyoming. For current statutes and suggested model language, see [Appendix C](#). For more information on why the appropriate level of supervision should be determined at the practice level, see the Issue Brief in [Appendix D](#).

### Chart Co-Signature Requirements

The third improvement ConnAPA is focusing on is in regard to chart co-signature requirements. Currently, supervising physicians must document approval of ALL prescriptions and orders of Schedule II and III drugs, even in routine cases. ConnAPA would like to allow decisions about when physician co-signature should be used to be made at the practice level, so that physician-PA teams can maximize efficiency in the delivery of patient care. Requiring co-signature in these instances places an unnecessary burden on physicians and PAs. Physicians are already required to exercise oversight of PA practice and are free to delegate prescriptive authority to a PA based on that PA's level of competence. When a supervising physician chooses to delegate prescriptive authority for schedule II and schedule III controlled substances, that supervising physician is making a determination that the PA is competent to determine when those medications are medically necessary. The physician's choice to delegate that authority serves as a de facto approval of future executions of that authority by the PA. Therefore, requiring a co-signature each time the PA exercises that authority is redundant. While both PAs and supervising physicians may want to review certain cases where patients are prescribed Schedule II or III medications, decisions about which cases to review should be made at the practice level. A requirement in state law for physicians to review every chart for patients prescribed a Schedule II or III medication by a PA can cause inefficiencies in patient care delivery. Strict co-signature requirements place a constraint both on the amount of time for *actual* quality physician oversight of the PA and on the amount of time for physician-patient interaction. If the proposed changes are made that ConnAPA seeks regarding no chart co-signature requirements, Connecticut would certainly not be the only state in the Northeast region with this type of practice. Maine, Maryland, New York, and Rhode Island all have no chart co-signature requirements in existing statute. Other states are Alaska, Arkansas, Florida, Idaho, Michigan, Minnesota, New Mexico, North Carolina, North Dakota, Ohio, Oregon, South Dakota, Wisconsin, and Wyoming. For current statute and proposed model language, please see Appendix E. For more information on why chart co-signature is something that should be determined at the practice level and not in state law, see the Issue Brief in Appendix F.

In summary, ConnAPA salutes the Public Health Committee for its unwavering efforts to improve efficiencies in the health care system. We respectfully ask that you consider our proposed amendments (regarding PA:MD ratio restriction, supervision language, and chart co-signature language) as outlined above and spelled out clearly in the suggested model language in the appendices below. Thank you for the opportunity to submit this testimony on issues that, we believe, once addressed, will further improve the delivery of health care to the residents of Connecticut.

Respectfully submitted,



Justin Champagne, MHS, PA-C  
President  
Connecticut Academy of Physician Assistants

## APPENDIX A: No Ratio Restriction (Current Statute and Model Language)

### Current Statute:

“Physician may not supervise more than six full-time PAs concurrently, or the part-time equivalent thereof.”

*-PA Practice Act, §20-12c(b)*

### Model Language:

Requirements for appropriate physician supervision of PAs are already defined in §20-12a(7) – definition of ‘supervision’. Ideally, this ratio provision above should be deleted.

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If it had to be replaced by something, the replacement language could be:

“It is the obligation of each team of physician(s) and physician assistant(s) to ensure that methods of physician supervision are clearly defined and appropriate to the types of medical services being provided and the level of competence of the PA.”

Or

“The number of PAs that a physician may supervise shall be determined at the individual practice level.”

**APPENDIX B: Issue Brief – Ratio of Physician Assistants to Supervising Physicians**

# STATE LAW ISSUES

## ISSUE BRIEF



### RATIO OF PHYSICIAN ASSISTANTS TO SUPERVISING PHYSICIANS

Physician assistants (PAs) practice medicine as part of a physician-led team. The physician-PA team is a well-accepted component of the health care workforce. Early state laws governing physician-PA practice restricted the number of PAs that a physician could supervise. These restrictions hampered physicians' ability to customize care for their particular specialty, setting and patient population. Allowing the number of supervised PAs to be determined at the practice level is preferable to restrictions in law.

PAs practice medicine with physician supervision. Throughout the history of the profession, PAs have had an unwavering commitment to team practice, with the physician as the head of the team.

Initially, the supervising physician-PA model envisioned a designated PA working beside a single physician in a primary care setting. As medical practice has embraced the use of PAs

as members of the team, however, this model has expanded. Single PAs and groups of PAs are now supervised by single physicians or groups of physicians in every medical and surgical specialty.

The first statutes and regulations governing supervising physician-PA practice were enacted in the early 1970s, at the beginning of the PA profession. State regulation of PA

*Throughout the history of the profession, PAs have had an unwavering commitment to team practice, with the physician as the head of the team.*

practice has been modified over the years to keep pace with the changing health care landscape. State laws also have evolved as the effectiveness of physician-PA team practice became more widely recognized.

Early state laws governing PA practice frequently put a limit on the number of PAs that could be supervised by a single physician. This limit was generally 2:1, and a few states had a mandated ratio of 1:1. As PA practice has become commonly accepted, many of these laws have been modified. Connecticut allows a supervising physician to supervise up to six PAs or the part-time equivalent of six PAs. California law specifies a 4:1 ratio, but emphasizes that this means “at any one time.” Further, licensing boards in several states may grant exceptions to the ratio restrictions. In a growing number of states, the laws and regulations do not limit the number of PAs that a physician may supervise.

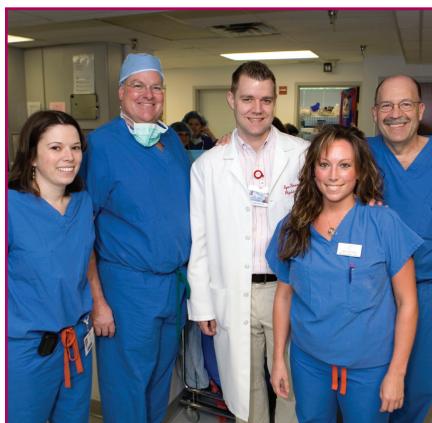
Several organizations have evaluated appropriate ratios of PAs per supervising physician. In 1996, the AAFP revised its policy on the ratio of PAs to supervising physicians. The AAFP deleted a sentence in its Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants policy that recommended a physician supervise no more than two “nonphysician” providers.<sup>1</sup>

The ACEP also supports the practice level determining its own ratios of PAs to supervising physicians. In 2007, ACEP approved a policy stating that the medical director of an emergency department should define the number of PAs whose clinical work can be simultaneously supervised by one emergency physician.<sup>2</sup>

The AMA adopted the recommendation of its Council on Medical Service in 1998. Charged with studying the issue of ratios, the Council recommended: “The appropriate ratio of physician-to-physician extenders should be determined by physicians at the practice level, consistent with good medical practice, and state law where relevant.”<sup>3</sup>

In a 2010 joint policy monograph with AAPA, the American College of Physicians endorses the idea of appropriate ratios being determined at the practice level: “AAPA and ACP encourage flexibility in federal and state regulation so that each medical practice determines appropriate clinical roles within the medical team, physician-to-PA ratios, and supervision processes, enabling each clinician to work to the fullest extent of his or her license and expertise.”<sup>4</sup>

The Federation of State Medical Boards also supports ratios being determined at the practice level. In their 2010 Essentials of a Modern Medical & Osteopathic Practice Act, FSMB



recommends that state laws simply require that “no physician should have under their supervision more staff, physician assistant or otherwise than the physician can adequately supervise.” FSMB does not recommend the inclusion of a specific number in state law.<sup>5</sup>

AAPA believes the appropriate number of PAs is best determined at the practice level, rather than in state law. Health professional regulation should allow for flexible and creative innovation and appropriate use of all members of the health care workforce. In many primary care settings, such as well-child or family planning clinics, a supervising physician could supervise multiple PAs. In a complex surgical case, the ratio might appropriately be 1:1. The guiding principle is that supervision must be defined and maintained, and that the supervising physician should be allowed some flexibility in staffing and team deployment.

Concurring with this principle in reaching its recommendation, the AMA Council on Medical Service stated: “Supervising physicians are the most knowledgeable of their own supervisory abilities and practice style, as well as the training and experience of physician extenders in their practice...Specified ratios of

supervisory physicians to physician extenders might restrict appropriate provision of care and could reduce access to care.”<sup>6</sup>

AAPA recommends that state laws contain no reference to specific ratios of PAs to a supervising physician.<sup>7</sup> This decision is best left to the supervising physician and should be customized to the nature of the practice, the complexity of the patient population, the experience of the PAs and the supervisory approach of the supervising physician or physicians. Therefore, state laws should contain an appropriate definition of supervision and require that supervision as defined be maintained at all times and in all settings.

## ADDITIONAL RESOURCES

For more information about modern PA law, PA education, PA scope of practice and the physician-PA team, visit our Issue Briefs page at [www.aapa.org/advocacy-and-practice-resources/issue-briefs](http://www.aapa.org/advocacy-and-practice-resources/issue-briefs). For additional information about state regulation, see our State Government and Licensing page at [www.aapa.org/advocacy-and-practice-resources/state-government-and-licensing](http://www.aapa.org/advocacy-and-practice-resources/state-government-and-licensing).

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- <sup>4</sup> American College of Physicians. (2009). *Internists and Physician Assistants: Team-Based Primary Care*. Philadelphia, PA.
- <sup>5</sup> Federation of State Medical Boards of the United States, Inc. (2010). *A Guide to the Essentials of a Modern Medical and Osteopathic Practice Act*. Euless, TX.
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**American Academy of  
PHYSICIAN ASSISTANTS**

950 North Washington Street | Alexandria, VA 22314 1552  
P 703 836 2272 | F 703 684 1924  
[www.aapa.org](http://www.aapa.org)

## APPENDIX C: Supervision (Current Statute and Model Language)

### Current Statute:

In hospital settings, supervision means the exercise by the supervising physician of oversight, control, and direction of the services of a PA. This includes but is not limited to: (1) continuous availability of direct communication either in person or by radio, telephone or telecommunications between PA and supervising physician; (2) active overview of PA's activities; (3) personal review of PA's practice at least weekly or more frequently as necessary to ensure quality patient care; (4) regular chart review; (5) delineation of plan for emergencies; (6) designation of an alternate physician who is registered with the department in absence of supervisor.

CONN. GEN. STAT. §20-12a(7)(A)

Supervision in settings other than hospitals means the exercise by the supervising physician of oversight, control and direction of the services of a PA. This includes but is not limited to: (1) continuous availability of direct communication either in person or by radio, telephone or telecommunications between PA and supervising physician; (2) active overview of PA's activities; (3) personal review of PA's practice through face-to-face meetings with the PA, at least weekly or more frequently as necessary to ensure quality patient care; (4) regular chart review, with documentation of review to be kept at practice site; (5) delineation of plan for emergencies; (6) designation of an alternate physician who is registered with the department in absence of supervisor.

CONN. GEN. STAT. §20-12a(7)(B)

The key phrase here is “at least weekly or more frequently”, and it should be deleted:

### Model Language (1):

In hospital settings, supervision means the exercise by the supervising physician of oversight, control, and direction of the services of a PA. This includes but is not limited to: (1) continuous availability of direct communication either in person or by radio, telephone or telecommunications between PA and supervising physician; (2) active overview of PA's activities; (3) personal review of PA's practice ~~at least weekly or more frequently~~ as necessary to ensure quality patient care; (4) regular chart review; (5) delineation of plan for emergencies; (6) designation of an alternate physician who is registered with the department in absence of supervisor.

CONN. GEN. STAT. §20-12a(7)(A)

Supervision in settings other than hospitals means the exercise by the supervising physician of oversight, control and direction of the services of a PA. This includes but is not limited to: (1) continuous availability of direct communication either in person or by radio, telephone or telecommunications between PA and supervising physician; (2) active overview of PA's activities; (3) personal review of PA's practice through face-to-face meetings with the PA, ~~at least weekly or more frequently~~ as necessary to ensure quality patient care; (4) regular chart review, with documentation of review to be kept at practice site; (5) delineation of plan for emergencies; (6) designation of an alternate physician who is registered with the department in absence of supervisor.

CONN. GEN. STAT. §20-12a(7)(B)

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Alternatively, it could be re-worded:

### Model Language (2):

“Supervision may include, but is not limited to: (iii) personal review by the supervising physician of the physician assistant's practice at least weekly or more frequently as necessary to ensure quality patient care.

**APPENDIX D: Issue Brief – Supervision of PAs: Access and Excellence in Patient Care**

# STATE LAW ISSUES

## ISSUE BRIEF



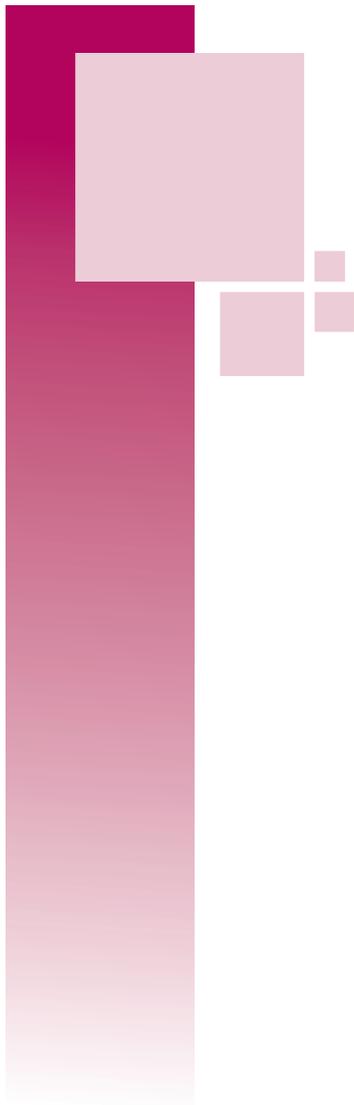
### SUPERVISION OF PHYSICIAN ASSISTANTS: ACCESS AND EXCELLENCE IN PATIENT CARE

Physician assistants (PAs) practice medicine with physician supervision. This concept is fundamental to the PA profession. The delegated care that PAs provide helps extend access and gives physicians added time to focus on more complex and challenging cases. Physician-PA teams benefit both patients and practitioners, and state laws that allow each practice to decide how to implement physician supervision maximize team effectiveness.

To extend a doctor's ability to care for patients, pioneering physicians created the PA profession to produce highly skilled professionals who are trained in the medical model. This model has proven to be exceptionally effective, and PAs are now integrated into medical and surgical teams in nearly all specialties and settings.

PAs are health care professionals licensed to practice medicine with

the supervision of a physician or physicians. The PA profession embraces this concept and considers supervision to be so essential to PA practice that supervision is included in the definition of PA. AAPA policy defines PAs in this manner: "Physician assistants are health professionals licensed or, in the case of those employed by the federal government, credentialed, to practice medicine with physician supervision."<sup>1</sup>



***The best patient care decisions are made as customized responses to individual practice situations.***

Academy policy goes on to endorse team practice in a changing health care system: “The AAPA believes that the physician-PA team relationship is fundamental to the PA profession and enhances the delivery of high quality health care. As the structure of the health care system changes, it is critical that this essential relationship be preserved and strengthened.”<sup>2</sup>

By law, every state requires PAs to practice with physician supervision. The majority of state laws governing PA practice have definitions identical or similar to AAPA’s model language on supervision, which states: “Supervision is defined as overseeing the activities of and accepting responsibility for, the medical services rendered by a physician assistant.”<sup>3</sup>

According to AAPA’s *Guidelines for State Regulation of Physician Assistants*, “[t]he guiding principles of supervision must be that it (a) protects the public health and safety, and (b) preserves the physician assistant’s access to physician consultation when indicated.”<sup>4</sup>

The best patient care decisions are made as customized responses to individual practice situations.

## **TEAM PRACTICE INVOLVES SHARED RESPONSIBILITY**

The concept of supervision does not mean that the supervising physician must always be present with the PA or direct every aspect of PA-provided care. PAs are trained in the medical model by physicians, PAs and faculty members who also teach physicians. Because they train using similar curriculum, training sites, faculties and facilities, physicians and PAs develop a similarity in medical

reasoning during their training that eventually leads to standardized thought in the clinical workplace; PAs think like doctors.<sup>5</sup>

The model of physician-PA practice has been described as delegated autonomy. Educational programs prepare PAs for autonomous decision making, and PAs arrive at practice ready to assume their role in the health care team. The practice arrangement established by physicians and PAs has been compared to the relationship between attending physicians and resident physicians. Although the depth and breadth of teamwork established by physicians and PAs who spend entire careers in practice together exceeds that which can be established by the brief tenure that physicians and residents share, there are many similarities between the attending-resident team and supervising physician-PA team. These key components include delegated autonomy, clear lines of accountability and the reciprocal responsibilities of providing supervision and seeking consultation.

Within the physician-PA team, as within teams of attending and junior physicians, there is an understanding that the PA is prepared for practice with an adequate fund of knowledge and set of clinical skills. The PA and physician define the PA’s role in the practice, and, within this role, the PA consults with and seeks input from the physician whenever there are clinical questions that exceed the PA’s expertise or when physician involvement is necessary for care. As with all practices, duties change over time; PAs assume greater responsibility and autonomy as their experience increases.

Physicians do not find PA supervision burdensome. Rather, because PAs and physicians use similar diagnostic and

therapeutic reasoning, adding a PA to a practice can allow the physician to focus on patient care that requires his or her full expertise. The PA, with the physician's direction, is expected to perform appropriately delegated tasks autonomously. Thus, the care provided by the PA is directed and its quality is assured by the physician. More routine care, initial evaluation of specialty patients, follow up, patient education and care coordination can be delegated to the PA. Complex patient problems, high acuity care, and management of difficult-to-treat conditions involve a greater proportion of physician time and expertise.

The most effective physician-PA team practices provide optimum patient care by designing a practice model where the skills and abilities of each team member are used most efficiently. Ideally, physicians are not involved in care best provided by PAs and, similarly, PAs do not undertake tasks best provided by physicians. Further, studies consistently find enhanced quality of care in settings that fully integrate physician-PA practice.<sup>6-8</sup>

## STATE LAWS AND PA SUPERVISION

Ideally, state laws should require supervision, define it and include provisions that allow for customization of health care teams to best meet the needs of patients. Because of the diversity of settings and specialties in which PAs practice, a specific requirement for on-site presence of the physician will be unavoidably arbitrary. Certain requirements may be appropriate for some settings, but would be too restrictive or permissive in others. For example, state laws that require a

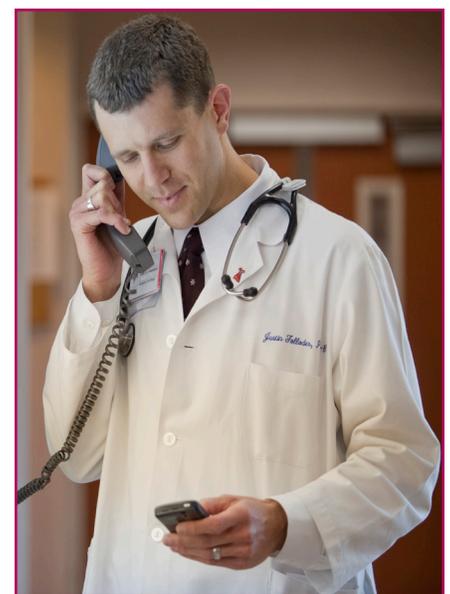
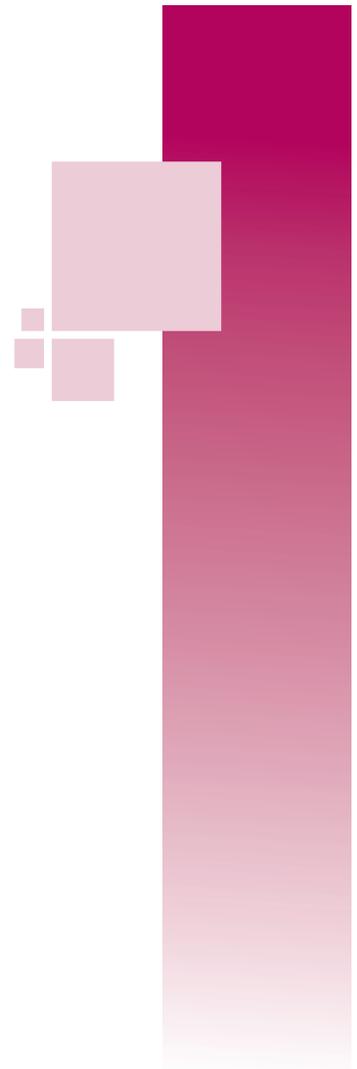
physician to be on-site for a specified amount of time can be a barrier to care in some circumstances. A much more patient sensitive approach is to allow the physician(s)-PA(s) teams to match supervision to the specific needs of the practice.

The American Medical Association (AMA) acknowledges the importance of requiring supervision while allowing physician flexibility in practice management. In 1995, the AMA House of Delegates adopted the *Guidelines for Physician/Physician Assistant Practice*, which includes:

- The role of the Physician Assistant(s) in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the Physician Assistant and based on the physician's delegatory style.
- The physician must be available for consultation with the Physician Assistant at all times either in person or through telecommunication systems or other means.
- The physician is responsible for clarifying and familiarizing the Physician Assistant with his supervising methods and style of delegating patient care.<sup>9</sup>

A growing number of state laws are being modified to improve a physician's ability to extend access to care through physician-PA teams. States are using language that defines supervision more broadly and are repealing laws that require physicians to be present at their practices for a set number of hours.

State laws governing the physician-PA team should include provisions that



require physician supervision, but allow for reasonable flexibility to allow doctors and PAs to provide patient care effectively and efficiently.

## ADDITIONAL RESOURCES

Physician-PA teams enhance health care and allow for greater patient access to high-quality care. To learn more about PA education, physician-PA team practice or the six key elements of modern PA practice acts, please visit AAPA's Resources page at [www.aapa.org/advocacy-and-practice-resources/issue-briefs](http://www.aapa.org/advocacy-and-practice-resources/issue-briefs).

## REFERENCES

- <sup>1</sup> American Academy of Physician Assistants. (2010) *Policy manual*. Retrieved December 23, 2009, from [www.aapa.org/about-aapa/policy-manual](http://www.aapa.org/about-aapa/policy-manual).
- <sup>2</sup> Ibid.
- <sup>3</sup> American Academy of Physician Assistants. (2005) *Model state legislation for physician assistants*. Retrieved December 23, 2009, from [www.aapa.org/advocacy-and-practice-resources/state-advocacy/490-model-state-legislation#Model%20State%20Legislation](http://www.aapa.org/advocacy-and-practice-resources/state-advocacy/490-model-state-legislation#Model%20State%20Legislation).
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American Academy of  
**PHYSICIAN ASSISTANTS**

950 North Washington Street | Alexandria, VA 22314 1552  
P 703 836 2272 | F 703 684 1924  
[www.aapa.org](http://www.aapa.org)

## APPENDIX E: Chart Co-Signature (Current Statute and Model Language)

### Current Statute:

#### **Section 20-12d. Medical functions performed by physician assistants. Prescriptive authority.**

(a) A physician assistant who has complied with the provisions of sections 20-12b and 20-12c may perform medical functions delegated by a supervising physician when: (1) The supervising physician is satisfied as to the ability and competency of the physician assistant; (2) such delegation is consistent with the health and welfare of the patient and in keeping with sound medical practice; and (3) when such functions are performed under the oversight, control and direction of the supervising physician. The functions that may be performed under such delegation are those that are within the scope of the supervising physician's license, within the scope of such physician's competence as evidenced by such physician's postgraduate education, training and experience and within the normal scope of such physician's actual practice. Delegated functions shall be implemented in accordance with written protocols established by the supervising physician. All orders written by physician assistants shall be followed by the signature of the physician assistant and the printed name of the supervising physician. A physician assistant may, as delegated by the supervising physician within the scope of such physician's license, (A) prescribe and administer drugs, including controlled substances in schedule IV or V in all settings, (B) renew prescriptions for controlled substances in schedule II, III, IV or V in all settings, and (C) prescribe and administer controlled substances in schedule II or III in all settings, provided in all cases where the physician assistant prescribes a controlled substance in schedule II or III, the physician under whose supervision the physician assistant is prescribing shall document such physician's approval of the order in the patient's medical record not later than one calendar day thereafter, and (D) prescribe and approve the use of durable medical equipment. The physician assistant may, as delegated by the supervising physician within the scope of such physician's license, request, sign for, receive and dispense drugs to patients, in the form of professional samples as defined in section 20-14c or when dispensing in an outpatient clinic as defined in the regulations of Connecticut state agencies and licensed pursuant to subsection (a) of section 19a-491 that operates on a not-for-profit basis, or when dispensing in a clinic operated by a state agency or municipality. Nothing in this subsection shall be construed to allow the physician assistant to request, sign for, receive or dispense any drug the physician assistant is not authorized under this subsection to prescribe.

–Conn. Gen. Stat. §20-12d

### Model Language:

#### **Section 20-12d. Medical functions performed by physician assistants. Prescriptive authority.**

(a) A physician assistant who has complied with the provisions of sections 20-12b and 20-12c may perform medical functions delegated by a supervising physician when: (1) The supervising physician... is satisfied as to the ability and competency of the physician assistant; (2) such delegation is consistent with the health and welfare of the patient and in keeping with sound medical practice; and (3) when such functions are performed under the oversight, control and direction of the supervising physician. The functions that may be performed under such delegation are those that are within the scope of the supervising physician's license, within the scope of such physician's competence as evidenced by such physician's postgraduate education, training and experience and within the normal scope of such physician's actual practice. Delegated functions shall be implemented in accordance with written protocols established by the supervising physician. All orders written by physician assistants shall be followed by the signature of the physician assistant and the printed name of the supervising physician. A physician assistant may, as delegated by the supervising physician within the scope of such physician's license, ~~(A) prescribe and administer drugs, including controlled substances in schedule II, III, IV or V in all settings, (B) renew prescriptions for controlled substances in schedule II, III, IV or V in all settings, and (C) prescribe and administer controlled substances in schedule II or III in all settings, provided in all cases where the physician assistant prescribes a controlled substance in schedule II or III, the physician under whose supervision the physician assistant is prescribing shall document such physician's approval of the order in the patient's medical record not later than one calendar day thereafter,~~ and ~~(D) may~~ prescribe and approve the use of durable medical equipment. The physician assistant may, as delegated by the supervising physician within the scope of such physician's license, request, sign for, receive and dispense drugs to patients, in the form of professional samples as defined in section 20-14c or when dispensing in an outpatient clinic as defined in the regulations of Connecticut state agencies and licensed pursuant to subsection (a) of section 19a-491 that operates on a not-for-profit basis, or when dispensing in a clinic operated by a state agency or municipality. Nothing in this subsection shall be construed to allow the physician assistant to request, sign for, receive or dispense any drug the physician assistant is not authorized under this subsection to prescribe.

–Conn. Gen. Stat. §20-12d

**APPENDIX F: Issue Brief – Chart Co-Signature and Physician Supervision of PAs**

# STATE LAW ISSUES

## ISSUE BRIEF

### CHART CO-SIGNATURE AND PHYSICIAN SUPERVISION OF PHYSICIAN ASSISTANTS: WHAT IS BEST FOR PATIENT CARE?

Physician assistants (PAs) practice medicine with physician supervision. Each PA's scope of practice is defined by delegation decisions of the supervising physician, consistent with the PA's education, facility policy and state laws. As physicians and institutions work to increase efficiency in medical practice, and as technology changes the way care is delivered, aspects of medical systems are being reevaluated. Among these is physician co-signature of PA chart entries and orders.

PAs are committed to practicing as members of physician-directed teams. Within these teams, chart co-signature (or "countersignature") is one method that physicians and PAs use to ensure physician oversight of PA practice.

Early state laws required all PA-written chart entries to be signed by physicians. However, these statutes were written without the experience of PA practice. Physician-PA teams have now been part of US health care for 40 years, and this experience confirms that — like many aspects of clinical medicine — the



best patient care decisions are made as customized responses to individual practice situations.

As health care progresses, laws and regulations governing physician-PA teams should be updated to reflect the evolutions in health care and the experience of PA practice. While preserving supervision and oversight is critical, requiring supervising physicians to co-sign every PA-written order or chart removes the doctors' discretion to exercise supervision in the way that works best for their practices. It also can place an unnecessary burden on the doctor, detracting from the efficiency of care the physician-PA team delivers.

*The best patient care decisions are made as customized responses to individual practice situations.*

## PHYSICIAN-DIRECTED PRACTICE

The PA profession was created in the late 1960s by physicians who envisioned a professional, trained in the medical model, who would work closely with a physician or group of physicians to enhance the doctor's ability to efficiently and effectively provide patient care. The landscape of health care has undergone many changes since then. However, the PA profession has remained true to the vision of its physician founders; PAs embrace

physician supervision and do not seek independent practice.

The relationship between PAs and physicians begins in PA educational programs where physicians, PAs and science professors provide instruction in a curriculum following the medical school model. Program applicants must complete at least two years of college courses in basic science and behavioral science as prerequisites to PA training. PA students typically share classes, facilities and clinical rotations with medical students. PA programs are usually 27 months in length,<sup>1</sup> and they begin with a year of basic medical science courses (anatomy, pathophysiology, pharmacology, physical diagnosis, etc.).

Following the basic and medical science classroom work, PA students begin clinical training. This training includes classroom instruction and clinical rotations in medical and surgical specialties (family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine and psychiatry). Prior to graduation, PA students complete, on average, 2,000 hours of supervised clinical practice.<sup>2</sup>

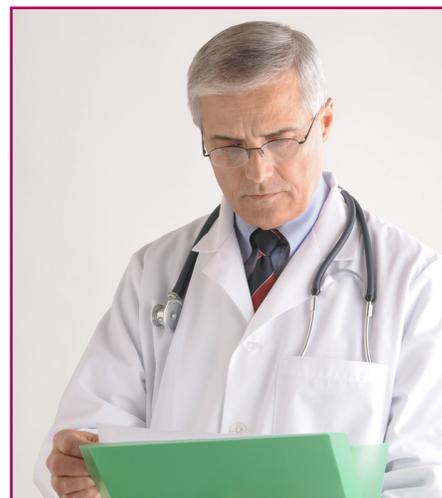
Because they train using similar curricula, training sites, faculties and facilities, physicians and PAs develop a similarity in medical reasoning during their schooling that eventually leads to standardized thought in the clinical workplace; PAs think like doctors.<sup>3</sup>

The definition of the PA profession, as stated in the policy of the American Academy of Physician Assistants

(AAPA), demonstrates PAs' commitment to practicing in physician-led teams: "Physician assistants practice medicine with supervision of licensed physicians."<sup>4</sup> This commitment to supervision by physicians is also evident in all state laws governing physician-PA practice. Although there is some variety in the way in which the requirement is stated, all state laws require a supervising physician to be available either in person or via telecommunication to consult with the PA when the he or she is seeing patients.<sup>5</sup>

## CHART CO-SIGNATURE AND OVERSIGHT

Currently, some states require a small fraction of charts to be co-signed, while many states have no requirement for chart co-signature by physicians in law or rule. There are times when chart co-signature by physicians is appropriate. For example, PAs have a responsibility to ensure that a supervising physician reviews complex problems and that the review is documented. Also, supervising physicians should review



PA-written chart entries, either every one or selected records, if that is the physician's preference. Further, licensed health care facilities, institutions and group practices are obligated to establish requirements — including co-signature requirements — that best suit the needs of the patients they serve.

The American Medical Association (AMA) recognizes the individual physician's role in determining specific aspects of PA practice and oversight. In 1995, the AMA House of Delegates adopted *Guidelines for Physician/Physician Assistant Practice* and, as noted in the guidelines, review of PA practice is the responsibility of the physician and PA:

- The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- The physician is responsible for the supervision of the physician assistant in all settings.
- The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.<sup>6</sup>

Additionally, the Joint Commission, an independent organization that accredits the majority of hospitals in the United States, recommends that each accredited organization determine the necessity for co-signature. The relevant standard states: "The hospital defines

the types of entries in the medical record made by nonindependent practitioners that require countersigning in accordance with law and regulation."<sup>7</sup>

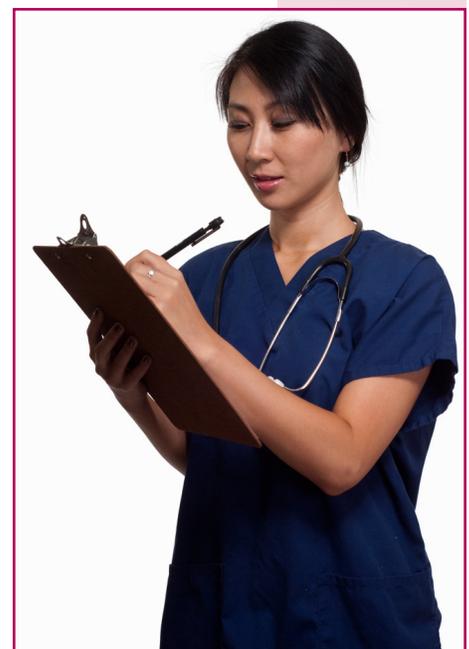
AAPA holds that physician oversight is the joint responsibility of the physician and the PA. According to AAPA's Model State Legislation for Physician Assistants:

"It is the obligation of each team of physician(s) and physician assistant(s) to ensure that the physician assistant's scope of practice is identified; that delegation of medical tasks is appropriate to the physician assistant's level of competence; that the relationship of, and access to, the supervising physician is defined; and that a process for evaluation of the PA's performance is established."<sup>8</sup>

## CHART CO-SIGNATURE AND PATIENTS

Rigid co-signature requirements in state law can diminish the opportunity for quality physician oversight. If, for example, a physician is required to counter-sign all routine orders, the doctor has less time available for in-depth discussion of specific cases with the PA.

The ideal system for physician oversight, then, is designed at the practice or facility level. If a physician is supervising a PA who is new to the practice, the doctor may decide to countersign, for a period of time, certain types of orders before they are implemented. If a physician-PA team has worked together for many years, a monthly case



conference may be the most quality-focused oversight system. Ultimately, the practice or facility must be able to decide what level of physician oversight PAs will require. This decision-making ability allows for greater responsiveness to physician, PA and patient needs.

## CHART CO-SIGNATURE AND ELECTRONIC RECORDS

Electronic medical records are increasingly taking the place of the traditional paper chart and, in instances where state law, facility guidelines or physician or PA preferences call for chart co-signature, physicians should be able to meet the co-signature requirement with notations in the electronic medical record. Thus, facilities or practices that require physician co-signature should invest in electronic medical records systems that allow physicians to co-sign records quickly and conveniently.

## ADDITIONAL RESOURCES

To ensure quality, efficient health care, practices or facilities should have the autonomy to decide whether physician co-signature of PA-written charts is appropriate for their organizations. For more information about PA scope of practice, physician-PA teams or about the six key elements of modern PA law, visit AAPA's Resources page at [www.aapa.org/advocacy-and-practice-resources/issue-briefs](http://www.aapa.org/advocacy-and-practice-resources/issue-briefs).



950 North Washington Street | Alexandria, VA 22314 1552  
P 703 836 2272 | F 703 684 1924  
[www.aapa.org](http://www.aapa.org)

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