



WISCONSIN ACADEMY OF PHYSICIAN ASSISTANTS

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July 12, 2013

Gene Musser, MD
Member, Medical Examining Board
State of Wisconsin
Department of Safety and Professional Services
PO Box 8935
Madison, WI 53708-8935

Re: Med 8 Proposals – “Traceability”

Dear Dr. Musser:

I am writing as the Legislative Committee Chair, on behalf of the Wisconsin Academy of Physician Assistants (WAPA).

In the summer of 2011, WAPA was approached by the MEB and asked our opinion about changing the physician to PA practice supervision ratio contained in Med 8.10(1) – currently 1:2. We consulted our members and our partners in the Wisconsin Medical Society (WMS) and Wisconsin Hospital Association (WHA) and ultimately our three organizations responded in unison that we would support a change to 1:4.

In the months following our response, the discussion expanded dramatically beyond this simple question, into a wide-ranging discussion about PA practice, physician supervision, and workplace pressures and practicalities. Participants in the discussions changed along the way, procedures for holding discussions changed, and many different proposals have been offered. While at times challenging for us to follow, it appears we are finally nearing the end of this process, and we believe we are arriving at a set of changes that will be beneficial for the PA practice, for the physicians and others who supervise and employ PAs, and for patient care.

We want to thank you for the leadership, wisdom, patience and persistence you have shown since taking over this project at the mid-point from your predecessor, as well as expressing our gratitude to our partners in WMS and WHA.

Attached to this letter is what we believe to be the most recent version of proposed changes to Med 8, crafted through our discussions with you, WMS and WHA, incorporating a 1:4 ratio for physician supervision, but also incorporating a variety of other changes. These are the changes you presented during the June 19th MEB meeting, and we believe they have the support of all parties.

At the June meeting, representatives of the MEB’s Council on Physician Assistants were invited before the Board to discuss the Council’s recommendations. During that discussion, it became clear that several PA Council recommendations were already incorporated in the document you presented, with the exception of one remaining issue that has been referred to as “traceability of the supervising physician.” (Referring

to the notion that when an adverse event involving care by a PA occurs generating or requiring investigation by the Division of Enforcement (DOE) there be some documentation identifying which physician was providing supervision to the PA for the particular patient encounter.) It is on that issue we wish to comment – and we believe that is the final issue requiring resolution.

No “Traceability” Requirement

We have said during multiple discussions that we believe Med 8 need not contain any specific provision relating to “tracing the identity of the supervising physician.” Our rationale is quite simple: PAs are educated, trained and licensed to practice only under the supervision of a physician; it is engrained in us to know at all times who is supervising us with respect to any given patient. Likewise, under new Med 10 provisions, physicians will now be required to provide “adequate supervision” to those they’re supervising. Whether noted in the written patient health care record or not, the identity of the supervising physician will always be readily available by some means. An affirmative requirement in Med 8 is simply unnecessary and any that is implemented runs a grave risk of being interpreted as imposing a new and onerous regulatory burden.

PAs are quite similar in terms of education, training and capabilities as NPs and APNPs, and the professions work in nearly identical capacities in most practice settings. That means we are also in competition for similar jobs in the healthcare marketplace. Unlike NPs and APNPs, PAs are physician-supervised, and while we understand that will necessarily mean PAs cannot be regulated in precisely the same fashion as NPs and APNPs, and that the MEB does not regulate NPs or APNPs, we do strongly believe that any PA regulations that are distinct from regulations on NPs and APNPs must be absolutely necessary for the purposes of patient safety. As hospitals, clinics, surgery centers and other healthcare employers continue searching for ways to cut costs, the elimination of work (and staff) required for regulatory compliance is front and center – unnecessary regulatory barriers will and do put PAs at a significant disadvantage when competing for jobs.

Notably, cases involving discipline of PAs (whether for substandard or erroneous care, or other unprofessional conduct) are historically exceedingly rare. Rarer still, are those where there was some question regarding the PA’s supervision. Though we have asked several times during the tenure of these discussions for a showing by the DOE staff of instances where the DOE attorneys or investigators have been unable to identify a PA’s supervising physician, or where the current absence of a “traceability” requirement has compromised patient safety or quality of care, we have never been provided anything concrete. The responses have simply been akin to, “we’ve had several cases where investigators had a very hard time identifying which physician was supervising.” Of note, even in the example presented by counsel at the June 19 Board meeting, it was clear that the DOE successfully identified the supervising physician involved, even if he was out of the country at the time. In the rare and unlikely event that a matter comes before the Board in which a provider is inclined to deny having supervisory responsibilities, or engage in “finger pointing” with another provider, no amount of documentation will keep that from happening. Ultimately, we not aware of any specific instance where this has been a problem, and absent any, we cannot support a provision in Med 8 requiring such documentation. We believe this is a solution in search of a problem.

“Readily Identifiable”

Though we strongly believe Med 8 should not contain an affirmative “traceability” requirement, we understand that others feel differently. Should the MEB ultimately feel compelled to create such a provision, we do feel the language approved at the June 19th MEB meeting is workable.

Specifically, at the June 19th meeting, the Board approved the following motion:

MOTION: Dr. Timothy Westlake moved, seconded by Dr. Suresh Misra, to add a provision to MED 8.07(2) stating “that the physician providing supervision be readily identifiable”. The Board directs DSPS staff to create language to indicate the responsibility for identification to be presented at the July 17, 2013 meeting of the Medical Examining Board. Motion carried.

Dr. Gene Musser voted nay in the matter of the above motion.

We are aware of two options proposed by Ms. Leatherwood to effectuate the direction to create language to indicate responsibility for identification. We harbor strong concerns that neither proposal accomplishes this end consistent with the above-approved motion. We understand the two choices she suggested to the PA Council to be:

Choice A: The physician providing supervision to the physician assistant must be readily identifiable in the medical records of the individual patient. Physician assistants are responsible for insuring the identity of the physician providing supervision is documented in the patient’s medical record.

Choice B: Physician assistants may have more than one supervising physician. The identity of the physician responsible for supervision of a physician assistant shall be documented in such that the physician supervising care of any patient can, at any time, be objectively identified by a third party.

The first of these incorporates the notion that the identification must be in the medical record. It is our understanding that that requirement was considered and rejected by the Board in the passage of the motion. We will not reiterate here all the reasons that requirement is impractical, though we stand firmly against any proposal that creates such a specific requirement.

The second choice also seems problematic for several reasons. First, and most obviously, it abandons the language already approved by the Board. Second, the language we were shown appears to be missing some words. We suspect it was intended to read in part “The identity of the physician responsible for supervision of a physician assistant shall be documented in such *a fashion* that the physician supervising care of any patient can, at any time, be objectively identified by a third party.” Third, establishing a requirement that documentation is such that “at any time, (the supervising physician) objectively identified by a third party” creates a nearly impossible standard of certainty, which employers will not know how to comply with. Fourth, and overriding all other aspects, this option does not accomplish the Board’s directive to indicate who has responsibility for the identification.

While it is not our first choice, we believe the language in the current motion is fine without any addition. While creating an affirmative requirement, we recognize the existing language (“MED 8.07(2) - the physician providing supervision must be readily identifiable”) does not specify how or where the information must be kept. This allows our employers the latitude to run their practices in the manner they currently enjoy and, as such we do not feel it will create a significant regulatory compliance barrier. Realizing this is not our first choice, and clearly is not the first choice of DOE staff; it probably represents an appropriate compromise. We believe this language provides hospitals, clinics, surgery centers and

other healthcare employers appropriate flexibility to determine how to maintain their own employment and risk management records during the current fast-changing healthcare regulatory environment.

Specifically, while we acknowledge that the motion does direct Department staff to present additional language for presentation to the MEB on July 17th specifying who is responsible for making such information available, we think this is a probably an even more unnecessary requirement. The fact that such a provision would appear in Med 8, entitled "Physician Assistants" (governing the scope and requirements of PA practice), *de facto* means the responsibility falls to the PA. At most, such language would be redundant and unnecessary, but more importantly would not address the concerns that have appeared to prompt the requirement in the first instance. If the concern is that a provider might be inclined to deny having a supervisory responsibility, is that really going to be avoided just because a PA writes it down somewhere? Again, it seems that we are chasing a response to a "what if," that has never been a problem and which does not admit of an airtight solution.

Again, we understand the direction given at the meeting, so if the MEB feels some language is necessary, we would propose the following:

8.07(2) – The physician providing supervision must be readily identifiable by the physician assistant through procedures commonly employed in the physician assistant's practice.

We believe this will clearly place the responsibility on the PA to know how to make information available that readily identifies the supervising physician for any particular patient encounter without increasing any regulatory burden. It seems to accomplish everyone's goals as best can be done.

Thank you again for taking over this project, and persevering to the end!

Sincerely,



Clark Collins, PA-C
Chair, WAPA Legislative & Government Affairs Committee

cc: Tim Westlake, MD
Tom Ryan
Mark Grapentine
Laura Leitch

Chapter Med 8

PHYSICIAN ASSISTANTS

Med 8.01	Authority and purpose.	Med 8.056	Board review of examination error claim.
Med 8.02	Definitions.	Med 8.06	Temporary license.
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Note: Chapter Med 8 as it existed on October 31, 1976 was repealed and a new chapter Med 8 was created effective November 1, 1976. Sections Med 8.03 to 8.10 as they existed on July 31, 1984 were repealed and recreated effective August 1, 1984.

Med 8.01 Authority and purpose. The rules in this chapter are adopted by the medical examining board pursuant to authority in ss. 15.08 (5), 227.11, 448.04 (1) (f) and 448.40, Stats., and govern the licensure and regulation of physician assistants.

History: Cr. Register, October, 1976, No. 250, eff. 11-1-76; am. Register, April, 1981, No. 304, eff. 5-1-81; am. Register, July, 1984, No. 343, eff. 8-1-84; correction made under s. 13.93 (2m) (b) 7., Stats., Register, May, 1989, No. 401; am. Register, October, 1996, No. 490, eff. 1-1-96; am. Register, December, 1999, No. 528, eff. 1-1-00.

Med 8.02 Definitions. (1) "Board" means the medical examining board.

(2) "Council" means the council on physician assistants.

(3m) "DEA" means the United States drug enforcement administration.

(4) "Educational program" means a program for educating and preparing physician assistants which is approved by the board.

(5) "Individual" means a natural person, and does not include the terms firm, corporation, association, partnership, institution, public body, joint stock association, or any other group of individuals.

(5m) "License" means documentary evidence issued by the board to applicants for licensure as a physician assistant who meet all of the requirements of the board.

(6) "Supervision" means to coordinate, direct, and inspect the accomplishments of another, or to oversee with powers of direction and decision the implementation of one's own or another's intentions.

History: Cr. Register, October, 1976, No. 250, eff. 11-1-76; am. (6) and (7) (b) to (e), Register, June, 1980, No. 294, eff. 7-1-80; r. (7), Register, July, 1984, No. 343, eff. 8-1-84; am. (2), (3) and (4) and cr. (3m), Register, October, 1996, No. 490, eff. 11-1-96; renum. (3) to be (5m) and am., am. (6), Register, December, 1999, No. 528, eff. 1-1-00.

Med 8.03 Council. As specified in s. 15.407 (2), Stats., the council shall advise the board on the formulation of rules on the education, examination, licensure and practice of a physician assistant.

History: Cr. Register, July, 1984, No. 343, eff. 8-1-84; am. Register, October, 1996, No. 490, eff. 11-1-96; am. Register, December, 1999, No. 528, eff. 1-1-00; correction made under s. 13.92 (4) (b) 7., Stats., Register August 2009 No. 644.

Med 8.04 Educational program approval. The board shall approve only educational programs accredited and approved by the committee on allied health education and accreditation of the American medical association, the commission for accreditation of allied health education programs, or its successor agency.

History: Cr. Register, July, 1984, No. 343, eff. 8-1-84; am. Register, October, 1994, No. 466, eff. 11-1-94; am. Register, December, 1999, No. 528, eff. 1-1-00.

Med 8.05 Panel review of applications; examinations required. The board may use a written examination prepared, administered and scored by the national commission on certification of physician assistants or its successor agency, or a

written examination from other professional testing services as approved by the board.

(1) APPLICATION. An applicant for examination for licensure as a physician assistant shall submit to the board:

(a) An application on a form prescribed by the board.

Note: An application form may be obtained upon request to the Medical Examining Board office located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

(b) After July 1, 1993, proof of successful completion of an educational program, as defined in ss. Med 8.02 (4) and 8.04.

(c) Proof of successful completion of the national certifying examination.

(cm) Proof that the applicant is currently certified by the national commission on certification of physician assistants or its successor agency.

(d) The fee specified in s. 440.05 (1), Stats.

(e) An unmounted photograph, approximately 8 by 12 cm., of the applicant taken no more than 60 days prior to the date of application which has on the reverse side a statement of a notary public that the photograph is a true likeness of the applicant.

(2) EXAMINATIONS, PANEL REVIEW OF APPLICATIONS. (a) All applicants shall complete the written examination under this section, and an open book examination on statutes and rules governing the practice of physician assistants in Wisconsin.

(b) An applicant may be required to complete an oral examination if the applicant:

1. Has a medical condition which in any way impairs or limits the applicant's ability to practice as a physician assistant with reasonable skill and safety.

2. Uses chemical substances so as to impair in any way the applicant's ability to practice as a physician assistant with reasonable skill and safety.

3. Has been disciplined or had certification denied by a licensing or regulatory authority in Wisconsin or another jurisdiction.

4. Has been convicted of a crime, the circumstances of which substantially relate to the practice of physician assistants.

5. Has not practiced as a physician assistant for a period of 3 years prior to application, unless the applicant has been graduated from an approved educational program for physician assistants within that period.

6. Has been found to have been negligent in the practice as a physician assistant or has been a party in a lawsuit in which it was alleged that the applicant has been negligent in the practice of medicine.

7. Has been diagnosed as suffering from pedophilia, exhibitionism or voyeurism.

8. Has within the past 2 years engaged in the illegal use of controlled substances.

9. Has been subject to adverse formal action during the course of physician assistant education, postgraduate training, hospital practice, or other physician assistant employment.

(c) An application filed under this chapter shall be reviewed by an application review panel of at least 2 council members des-

igned by the chairperson of the board to determine whether an applicant is required to complete an oral examination under par. (a). If the application review panel is not able to reach unanimous agreement on whether an applicant is eligible for licensure without completing an oral examination, the application shall be referred to the board for a final determination.

(d) Where both written and oral examinations are required they shall be scored separately and the applicant shall achieve a passing grade on both examinations to qualify for a license.

(3) **EXAMINATION FAILURE.** An applicant who fails to receive a passing score on an examination may reapply by payment of the fee specified in sub. (1) (d). An applicant may reapply twice at not less than 4-month intervals. If an applicant fails the examination 3 times, he or she may not be admitted to an examination unless the applicant submits proof of having completed further professional training or education as the board may prescribe.

Note: There is no provision for waiver of examination nor reciprocity under rules in s. Med 8.05.

(4) **LICENSURE; RENEWAL.** At the time of licensure and each biennial registration of licensure thereafter, a physician assistant shall list with the board the name and address of the supervising physician and shall notify the board within 20 days of any change of a supervising physician.

History: Cr. Register, July, 1984, No. 343, eff. 8-1-84; am. (intro.), r. and recr. (2), Register, October, 1989, No. 406, eff. 11-1-89; am. (1) (b), cr. (1) (cm), Register, July, 1993, No. 451, eff. 8-1-93; am. (intro.), (1) (intro), (cm), (2) (b) 4., 5., 6., (c) and (4), Register, October, 1996, No. 490, eff. 11-1-96; am. (2) (a), (b) (intro.) and 3. to 5., r. and recr. (2) (b) 1. and 2., cr. (2) (b) 7. to 11., Register, February, 1997, No. 494, eff. 3-1-97; am. (intro.), (1) (intro.) and (cm), (2) (b) 5., (c), (d) and (4), r. (2) (b) 10. and 11., Register, December, 1999, No. 528, eff. 1-1-00.

Med 8.053 Examination review by applicant. (1) An applicant who fails the oral or statutes and rules examination may request a review of that examination by filing a written request and required fee with the board within 30 days of the date on which examination results were mailed.

(2) Examination reviews are by appointment only.

(3) An applicant may review the statutes and rules examination for not more than one hour.

(4) An applicant may review the oral examination for not more than 2 hours.

(5) The applicant may not be accompanied during the review by any person other than the proctor.

(6) At the beginning of the review, the applicant shall be provided with a copy of the questions, a copy of the applicant's answer sheet or oral tape and a copy of the master answer sheet.

(7) The applicant may review the examination in the presence of a proctor. The applicant shall be provided with a form on which to write comments, questions or claims of error regarding any items in the examination. Bound reference books shall be permitted. Applicants shall not remove any notes from the area. Notes shall be retained by the proctor and made available to the applicant for use at a hearing, if desired. The proctor shall not defend the examination nor attempt to refute claims of error during the review.

(8) An applicant may not review the examination more than once.

History: Cr. Register, February, 1997, No. 494, eff. 3-1-97.

Med 8.056 Board review of examination error claim. (1) An applicant claiming examination error shall file a written request for board review in the board office within 30 days of the date the examination was reviewed. The request shall include all of the following:

(a) The applicant's name and address.

(b) The type of license for which the applicant applied.

(c) A description of the mistakes the applicant believes were made in the examination content, procedures, or scoring, including the specific questions or procedures claimed to be in error.

(d) The facts which the applicant intends to prove, including reference text citations or other supporting evidence for the applicant's claim.

(2) The board shall review the claim, make a determination of the validity of the objections and notify the applicant in writing of the board's decision and any resulting grade changes.

(3) If the decision does not result in the applicant passing the examination, a notice of denial of license shall be issued. If the board issues a notice of denial following its review, the applicant may request a hearing under s. SPS 1.05.

Note: The board office is located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

History: Cr. Register, February, 1997, No. 494, eff. 3-1-97; correction in (3) made under s. 13.92 (4) (b) 7., Stats., Register November 2011 No. 671.

Med 8.06 Temporary license. (1) An applicant for licensure may apply to the board for a temporary license to practice as a physician assistant if the applicant:

(a) Remits the fee specified in s. 440.05 (6), Stats.

(b) Is a graduate of an approved school and is scheduled to take the examination for physician assistants required by s. Med 8.05 (1) or has taken the examination and is awaiting the results; or

(c) Submits proof of successful completion of the examination required by s. Med 8.05 (1) and applies for a temporary license no later than 30 days prior to the date scheduled for the next oral examination.

(2) (a) Except as specified in par. (b), a temporary license expires on the date the board grants or denies an applicant permanent licensure. Permanent licensure to practice as a physician assistant is deemed denied by the board on the date the applicant is sent notice from the board that he or she has failed the examination required by s. Med 8.05 (1) (c).

(b) A temporary license expires on the first day of the next regularly scheduled oral examination for permanent licensure if the applicant is required to take, but failed to apply for, the examination.

(3) A temporary license may not be renewed.

(4) An applicant holding a temporary license may apply for one transfer of supervising physician and location during the term of the temporary license.

History: Cr. Register, July, 1984, No. 343, eff. 8-1-84; am. (1) (b) and (c), Register, October, 1989, No. 406, eff. 11-1-89; sin. (2) (a), Register, January, 1994, No. 457, eff. 2-1-94; am. (1) (intro.) and (2) (a), Register, October, 1996, No. 490, eff. 11-1-96; am. (1) (intro.) and (b) to (3), cr. (4), Register, December, 1999, No. 528, eff. 1-1-00.

Med 8.07 Practice. (1) SCOPE AND LIMITATIONS. In providing medical care, the entire practice of any physician assistant shall be under the supervision of one or more licensed physicians or a physician exempt from licensure requirements pursuant to s. 448.03(2)(b), Stats. The scope of practice is limited to providing medical care specified in sub. (2). A physician assistant's practice may not exceed his or her educational training or experience and may not exceed the scope of practice of the supervising physician providing supervision. A medical care task assigned by the a supervising physician to a physician assistant may not be delegated by the physician assistant to another person.

(2) **MEDICAL CARE.** Medical care a physician assistant may provide include:

(a) Attending initially a patient of any age in any setting to obtain a personal medical history, perform an appropriate physical examination, and record and present pertinent data concerning the patient in a manner meaningful to the supervising physician.

(b) Performing, or assisting in performing, routine diagnostic studies as appropriate for a specific practice setting.

(c) Performing routine therapeutic procedures, including, but not limited to, injections, immunizations, and the suturing and care of wounds.

(d) Instructing and counseling a patient on physical and mental health, including diet, disease, treatment and normal growth and development.

(e) Assisting the supervising physician in a hospital or facility, as defined in s. 50.01 (1m), Stats., by assisting in surgery, making patient rounds, recording patient progress notes, compiling and recording detailed narrative case summaries and accurately writing or executing orders under the supervision of a licensed physician.

(f) Assisting in the delivery of medical care to a patient by reviewing and monitoring treatment and therapy plans.

(g) Performing independently evaluative and treatment procedures necessary to provide an appropriate response to life-threatening emergency situations.

(h) Facilitating referral of patients to other appropriate community health—care facilities, agencies and resources.

(i) Issuing written prescription orders for drugs, provided the physician assistant has had an initial, and at least annual thereafter, review of the physician assistant's prescriptive practices by a physician providing supervision. Such reviews shall be documented in writing, signed by the reviewing physician and physician assistant and made available to Board for inspection upon reasonable request, under the supervision of a licensed physician and in accordance with procedures specified in s. Med 8.08 (2).

History: Cr. Register, July, 1984, No. 343, eff. 8-1-84; am. (2) (i), Register, July, 1994, No. 463, eff. 8-1-94; am. (1) and (2) (intro.), Register, October, 1996, No. 490, eff. 11-1-96; am. (1), (2) (intro.), (c), (e), (1) and (i), Register, December, 1999, No. 528, eff. 1-1-00.

Med 8.08 Prescribing limitations. (1) ~~A physician assistant may not prescribe or dispense any drug independently. A physician assistant may only prescribe or dispense a drug pursuant to written guidelines for supervised prescriptive practice. The guidelines shall be kept on file at the practice site and made available to the board upon request.~~

~~(2) A physician assistant may issue a prescription order only if all the following conditions apply:~~

~~(a) The physician assistant issues the prescription order only in patient situations specified and described in established written guidelines, including the categories of drugs for which prescribing authority has been authorized. The guidelines shall be reviewed at least annually by the physician assistant and his or her supervising physician.~~

~~(b) The supervising physician and physician assistant determine by mutual agreement that the physician assistant is qualified through training and experience to issue a prescription order as specified in the established written guidelines.~~

~~(c) The supervising physician is available for consultation as specified in s. Med 8.10 (3).~~

~~(d) The prescription orders prepared under procedures in this section contain all information required under s. 450.11 (1), Stats.~~

~~(3)(a) A physician who supervises the prescribing practice of a physician assistant shall conduct a periodic review of the prescription orders prepared by the physician assistant to ensure quality of care. In conducting the periodic review of the prescriptive~~

~~practice of a physician assistant, the supervising physician shall do at least one of the following:~~

~~1. Review a selection of the prescription orders prepared by the physician assistant.~~

~~2. Review a selection of the patient records prepared by the physician assistant practicing in the office of the supervising physician or at a facility or a hospital in which the supervising physician has staff privileges.~~

~~3. Review by telecommunications or other electronic means the patient record or prescription orders prepared by the physician assistant who practices in an office facility other than the supervising physician's main office of a facility or hospital in which the supervising physician has staff privileges.~~

~~(b) The supervising physician shall determine the method and frequency of the periodic review based upon the nature of the prescriptive practice, the experience of the physician assistant, and the welfare of the patients. The process and schedule for review shall indicate the minimum frequency of review and identify the selection of prescriptive orders or patient records to be reviewed.~~

History: Cr. Register, July, 1984, No. 343, eff. 8-1-84; r. (3), Register, July, 1994, No. 463, eff. 8-1-94; am. (1), (2) (intro.), (a), (b), (c), (d), (e) 1., 2. and 3., Register, October, 1996, No. 490, eff. 11-1-96; am. (1) to (2) (d), (e) 2. and 3., Register, December, 1999, No. 528, eff. 1-1-00; CR 09-006: am. (1) and (2) (a), r. (2) (e), cr. (3) Register August 2009 No. 644, eff. 9-1-09.

Med 8.09 Employee status. No physician assistant may be self-employed. If the employer of a physician assistant is other than a licensed physician, the employer shall provide for, and may not interfere with, the supervisory responsibilities of the physician, as defined in s. Med 8.02 (6) and required in ss. Med 8.07 (I) and 8.10.

History: Cr. Register, July, 1984, No. 343, eff. 8-1-84; am. Register, October, 1996, No. 490, eff 11-1-96.

Med 8.10 Employment requirements; supervising physician responsibilities. (1) No physician may ~~concurrently~~ supervise more than ~~4 on duty~~² physician assistants at any time. ~~Nothing herein shall limit the number of physician assistants for whom a physician may provide supervision over time, unless the physician submits a written plan for the supervision of more than 2 physician assistants and the board approves the plan.~~ A physician assistant may be supervised by more than one physician while on duty.

~~(2) Another licensed physician may be designated by the supervising physician to supervise a physician assistant for a period not to exceed 8 weeks per year. Except in an emergency, the designation shall be made in writing to the substitute supervising physician and the physician assistant. The supervising physician shall file with the board a copy of the substitution agreement before the beginning date of the period of his or her absence.~~

~~(3)(2) The~~^A supervising physician or substitute supervising physician shall be available to the physician assistant at all times for consultation either in person or within 15 minutes of contact by telecommunications or other electronic means.

~~(4)(3) A supervising physician shall visit and conduct an on-site review of facilities attended by the physician assistants at least~~

~~once a month. Any patient in a location other than the location of the supervising physician's main office shall be attended personally by the physician consistent with his or her medical needs. The constant physical presence of a supervising physician is not required, however the methods utilized for supervision must allow the physician to fulfill any supervisory duties required by law including competent medical practice.~~

History: Cr. Register, July, 1984, No. 343, eff. 8-1-84; am. (1), Register, December, 1999, No. 528, eff. 1-1-00; CR 09-006: am. (3) Register August 2009 No. 644, eff. 9-1-09.