

HB 509  
*NOTABLE CHANGES TO THE MEDICAL PRACTICE ACT & PHYSICIAN ASSISTANT  
ACT<sup>1</sup>*

I. ADMINISTRATIVE CHANGES

a. LICENSURE:

i. Exams:

HB 509 states that for applicants that have not passed a board approved licensing, specialty or recertification exam within seven years of the date of application for licensure, the board may require a period of evaluated clinical experience or the successful completion of an examination. Physicians subject to discipline may be subject to the same requirements. An applicant that fails a third examination attempt cannot sit for an examination again until having completed one year of post-graduate ACGME training. A person that has previously passed a board approved examination does not have to stand for another examination as a condition of renewing a current, unrestricted license. (43-34-26)

ii. Provisional, Teaching, Temporary and Institutional Licenses:

Until this year, the MPA provided for:

- Provisional licenses to applicants that possess all the qualifications necessary to obtain a license except that they have not passed the required examinations. Provisional licenses may only be issued if the board determines there is an unfilled need in a geographic area and the licensee is limited to practicing in such an area. A provisional license was valid for one year and could be renewed for one additional year upon a showing by the licensee he or she has practiced in the specified geographic area. (43-34-34)
- Teaching licenses for board licensed physicians of other states and foreign countries for the purpose of teaching at a board approved college or affiliated clinic. (43-34-29.1)
- Institutional licenses for graduates of board approved schools that are employed by a state institution or medical college. The institution is granted the license authorizing the

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<sup>1</sup> Note: The Georgia Composite Medical Board has not adopted rules and regulations yet that reflect the changes made by HB 509. As a result, it is currently unknown how the board will interpret many of HB 509's provisions.

individual to practice medicine with appropriate supervision in the institution and the individual may not receive any remuneration from patients. These have been phasing out and could only be renewed if issued prior to 1980. (43-34-33)

Under the revised MPA:

- Provisional licenses are stricken in their entirety and will no longer be issued; however one possessing a provisional license prior to 1979 may continue to renew it. (43-34-34)
- Teaching licenses were retained in the revision but will be valid for only two years and may only be renewed for one additional year. (43-34-29)
- Institutional licenses have been changed so that they may be issued only under exceptional circumstances for graduates of foreign medical schools. They are issued jointly to the institution and the applicant and the applicant must work under proper supervision. (43-34-33)

iii. Reciprocity:

Under the prior statute, the board could grant by reciprocity a license to a licensee of another jurisdiction that requires equal or higher qualifications and upon the same basis such other jurisdictions reciprocate with Georgia. There were additional requirements licensees from other states had to satisfy depending on the date they received their license from the other jurisdiction. (43-34-29)

Under the revised statute, the board may grant a license by reciprocity to licensees of other jurisdictions that simply require equal or higher qualifications. The other jurisdictions no longer have to reciprocate with Georgia. (43-34-28)

iv. Prohibition on Specialty Specific Licenses:

Under the prior statute, a physician was granted the "absolute authority" to practice medicine once granted a license. (43-34-27; 43-34-35)

The initial drafts of the revised MPA had language that could be interpreted as authorizing the board to limit a physician's license to a particular specialty.

MAG worked to have that language removed and the version that was signed into law explicitly states that the board shall not limit or restrict a license to a medical specialty (43-34-5(d)), and the language stating that a license once granted confers the absolute authority to practice medicine is retained. (43-34-26; 43-34-35)

v. Licensure Status:

The revision provides the board with the authority to create rules regarding licensure status, such as active and inactive. This change was made because the previous version of the MPA references a physician's licensure status but the statute did not explicitly authorize the board to create categories of licensure status. (43-34-5)

b. DISCIPLINARY AUTHORITY:

i. Conduct:

In addition to the conduct for which the board had the statutory authority to discipline a licensee, the revised MPA explicitly provides disciplinary authority for conduct that was previously unprovided for, was implicitly provided for, or was located in another chapter of the Georgia Code or the rule and regulations of the board:

1. Cheated on or attempted to subvert a board examination (§43-34-8(a)(14))
2. Acts of sexual abuse or exploitation of a patient or guardian or parent of a minor patient (§43-34-8(a) (15))
3. Mistreating or abandoning patients or their records. A physician that complies with chapter 33 of title 31 governing medical records shall not be considered to have abandoned records. (§43-34-8(a) (16))
4. Conduct that discredits the profession (§43-34-8(a) (17))
5. Failure to furnish records to the board pursuant to a subpoena or failed to answer questions on a renewal of the license. (§43-34-8(a) (18))
6. Failure to maintain appropriate medical or other records. (§43-34-8(a) (19))

7. Failure to comply with OSHA Standards for infection control. (§43-34-8(a) (20))
8. Failure to comply with federal laws and standards relating to the practice of medicine, the regulation of drugs, the delivery of health care, or other related laws. (§43-34-8(a) (21)).
9. Failure to pay child support (§43-34-8(a) (22))
10. Failure to repay student loans (§43-34-8(a) (23))
11. Being employed by one the physician delegates medical acts to, is responsible for supervising, or enters a protocol or job description with. (§43-34-8(a) (24))

ii. Sanctions:

In addition to the sanctions the board had the statutory authority to impose under the previous version of the MPA, the revised MPA provides for additional sanctions that were unprovided for, were implied, or were located in another chapter of the Georgia Code or the rules and regulations of the board:

1. Medical community service (§43-34-5(9))
2. Probation for a definite or indefinite period of time. (§43-34-8(b)(1)(B))
3. A fine not to exceed \$3,000 per violation. (§43-34-8(b)(1)(G))
4. A reasonable fine to reimburse the board for administrative costs. (§43-34-8(b)(1)(H))
5. Passage of a minimum competency examination. (§43-34-8(b)(1)(I))
6. Board approved medical education. (§43-34-8(b)(1)(J))
7. Condition the penalty on the licensee's submission to, and completion of, the care, counseling or treatment by physicians. (§43-34-8(b)(1)(K))
8. Mental or physical evaluations. (§43-34-8(b)(1)(L))

iii. Hearings:

1. If a licensee fails to appear for a hearing after 30 days notice, the board may proceed to hear evidence and take action against such licensee as if the licensee were present. If notice of a hearing or final disciplinary action is sent certified, return receipt requested to the licensee's last know address and is returned, or the licensee cannot be located after diligent efforts, the executive director of the board is deemed to be the agent of the licensee for service of such notice. (§43-34-8(l))

II. MEDICAL PRACTICE ACT:

a. Definition of "The Practice of Medicine":

The definition of "the practice of medicine" has been amended to include attaching the term "physician" to one's name in addition to the terms previously included in the definition (doctor, surgeon, M.D., etc). (§43-34-21). In addition, attaching the term "physician", as well as the others, to one's name without being licensed pursuant to the Medical Practice Act is deemed a violation of said Act. (43-34-22).

b. Allied Providers

i. Radiology Assistants:

Language is added defining the term "radiologist assistant" as an advanced level certified radiologic technologist who assist radiologists in performing advanced diagnostic imaging procedures under the direction of a supervising radiologist and may include injecting diagnostic agents, performing diagnostic aspirations and localizations, and assisting radiologists with other invasive procedures. The board has the authority to determine the levels of physician supervision and the procedures that may be performed by assistants. (§43-34-12) The intent for including this language is not clear.

ii. Medical Assistants:

Medical assistants are authorized to perform medical tasks, including administering subcutaneous and intramuscular injections, nebulizer treatments, obtaining vital signs, and other tasks approved by the board under the supervision of a physician in the physician's office. (§43-34-44). This language was necessary after the board received an opinion from legal counsel that, because medical assistants are

not licensed, absent direct supervision by a physician, medical assistant were not authorized to administer injections. The opinion caused disruption in physician's offices that utilize medical assistants. (43-34-44)

iii. Polysomnography Technologists:

The revision of the medical practice act provides for the performance of certain medical tasks by "polysomnography technologists". "Polysomnography" is defined in part as the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. A "polysomnography technologist" is one that performs polysomnography under the supervision of a physician. (§43-34-45). This language was necessary due to an opinion received by the board from legal counsel that, because polysomnography technologists are not licensed and their tasks encompassed the scope of practice for respiratory care therapists, it was not appropriate to delegate such tasks to them. (43-34-45)

iv. Physician's Assistants:

See below

v. APRNs:

Physician's may delegate to APRN's the authority to pronounce and certify death. (§43-34-35)

vi. Pharmacists & Nurses:

Although not enacted as part of the revision of the medical practice act, HB 217 nonetheless amends the medical practice act to authorize a physician to prescribe influenza vaccine and epinephrine to a group of patients for administration by a pharmacist or nurse.

Under HB 217, the physician and pharmacist or nurse are authorized to enter into an influenza vaccine protocol agreement. The agreement contains an influenza vaccine order by which the physician may prescribe influenza vaccine and epinephrine to a group of patients and authorize administration by a pharmacist or nurse. The agreement must:

- Contain the name, address, telephone number, and professional license number of the physician and pharmacist or nurse;

- Contain a provision for immediate consultation between the physician and pharmacist or nurse;
- Require the pharmacist or nurse to provide the vaccine recipient with the appropriate and current VIS;
- Require the pharmacist or nurse or his or her employer to retain documentation of each dose administered, and shall include at least:
  - i. The administering pharmacist's or nurse's name, address, telephone number and professional license number;
  - ii. The name, dose, manufacturer and lot number of the influenza vaccine;
  - iii. The vaccine recipient's name, address, date of birth and telephone number;
  - iv. The date of administration and injection site;
  - v. A signed and dated form by which the recipient acknowledges receipt of the VIS and consents to the administration; and
  - vi. The occurrence of any adverse events.
- Require the pharmacist or nurse to enter the recipient's information in GRITS;
- Require the recipient remain under observation for a period not less than 15 minutes;
- Contain procedures to follow upon the occurrence of an adverse event;
- Provide for prioritization of recipients in the event supply is limited;
- Be renewed biennially.

A physician entering such a protocol must register with GRITS and the pharmacist or nurse must be located in the physician's county of registration with GRITS or a county contiguous thereto. A physician may not enter such an agreement with more than 10 pharmacists or nurses unless the pharmacists and/or nurses are all employees or agents of the same corporate entity and are in the same public health district.

Physicians are not authorized to prescribe vaccines other than influenza vaccine pursuant to a influenza vaccine protocol agreement or an influenza vaccine order. It is unlawful for a physician that is employed by a pharmacist or nurse to enter a protocol with or otherwise delegate acts to such pharmacist or nurse, as well as a physician employed by a pharmacist or nurse also employed by the pharmacy.

Physicians are immune from criminal or civil liability or discipline for unprofessional conduct for entering a influenza vaccine protocol agreement, issuing an influenza vaccine order, or the acts or omissions of a pharmacist or nurse pursuant to the agreement, provided the pharmacist or nurse are not employees of the physician.

A pharmacist or nurse may not administer influenza vaccine pursuant to a protocol to any child under 13 without an individual prescription from a physician, or to children under 18 without the consent of a parent or legal guardian. (43-34-26.4)

### III. PHYSICIAN ASSISTANTS ACT

#### a. Applications & Licensure:

Under the law prior to July 1, 2009, the physician responsible for the PA was the applicant and the PA was licensed to the physician. (43-34-102(1); 43-34-102(8); 43-34-103(b)(1); 43-34-103(b)(3)).

Under the revision, the PA is the applicant for licensure, but remains licensed to the physician. (§43-34-102(1); 43-34-103; §43-34-102(2);(7);(9)). However, the physician must also make an application to the board for approval to utilize the PA. (§43-34-103(a)(2)). This arrangement relieves the burden on the physician of being responsible for renewing the license for the PA, but ensures PAs' do not practice independently as they are licensed to the physician and do not possess an independent license.

#### b. Job Descriptions:

In applying for licensure, a PA must provide evidence of competency in a health care area related to the job description, and in applying for approval to use a PA, a physician must include the job description. (43-34-103(a)(1)(B); 43-34-103(a)(2)(ii)). Therefore, it will be necessary for the PA and physician to develop a job description prior to making applications for licensure and use of the PA.

Additionally, the revision makes explicitly clear that a PA is not authorized to perform any medical acts except as approved in a job description with a physician, and must have a job description signed by the physician and approved by the board at all times while providing patient services. PAs have no independent scope of practice. (43-34-103(a)(1)(B)(ii); 43-34-103(c)(1).

c. Medical Tasks:

i. Locations:

Under the prior law, PAs were limited to performing duties only in the principal offices of the physician which were those health facilities where the physician regularly sees patients. (§43-34-103(d)). Under the revision, the reference to the physician's "principal offices" and "health facilities" are removed and PAs may perform tasks in facilities where the physician regularly sees patients.

ii. Hospital Duties

Under the law prior to July 1, 2009, despite being limited to the physician's principal offices, PAs were authorized to make "hospital rounds". (§43-34-103(d)). Under the revision, this language is broadened by authorizing PAs to perform "hospital duties". (§43-34-103(d)).

iii. Prescriptions

The majority of changes with regard to PA-issued prescriptions provide PAs with similar authority as APRNs.

1. General:

Under the previous statute, it was unclear if a PA was deemed to be merely carrying out the prescription order of the physician (the original intent of the statute) or had prescriptive authority (as later determined by the AG due to amendments). (43-34-102(3); 43-34-103(e.1)). PAs were also required to carryout a prescription on a form using statutorily mandated language. (43-34-103(e.1)(3), and the board was required to adopt a formulary of drugs that may be included in the job description that a PA could prescribe. (43-34-103(e.1)(9)(B)).

Under the revision it is clarified that a PA has prescriptive authority if delegated in the job description. (43-34-103(e.1)(1); 43-34-102(5); the statutorily mandated language on a prescription is replaced with a requirement that certain information be on the prescription (43-34-103(e.1)(3); and the language requiring the board to establish a formulary is stricken. (43-34-103(e.1)(9)(B)).

2. Continuing Education

PAs are required to complete three hours of continuing education biennially in practice specific pharmaceuticals they are delegated the authority to order. (43-34-103(e.1)(12)).

3. DEA Registration:

Consistent with Georgia Code 16-13-21, the Physician Assistant Act explicitly authorizes a PA to register with the DEA. (43-34-103(e.1)(11)).

4. Patients' Right to See the Physician:

Under the previous statute, the PA was required to notify a patient receiving a prescription from the PA that the patient had the right to first see the physician. Under the revised statute, the PA or office staff may notify the patient. (43-34-103(e.1)(4)).

5. Refills:

Under the previous statute, a PA could not issue a prescription for more than 30 days unless it was for a chronic condition in which case it could be issued for 90 days. In addition, a PA could authorize refills for only six months, except in the case of oral contraceptives or other drugs approved by the board which could be refilled for up to 12 months. (43-34-103(e.1)(5)).

Under the revised statute, the limitation on the initial duration is stricken and all refills are authorized for up to 12 months. (43-34-103(e.1)(5)).

iv. Pronounce Death:

PAs are authorized to pronounce and certify death. (43-34-103(j)).

d. Physician Responsibilities:

i. Acts of the PA:

As under the previous statute, the physician is responsible for the medical acts of the PA and shall adequately supervise the PA. (43-34-(e.1)(1)).

ii. Prescription Review:

Under the previous statute, the physician was required to countersign prescriptions carried out by a PA within seven days. (43-34-103(e.1)(7)(B)). Under the revised statute, the physician must review prescriptions issued by the PA within the last 30 days, and the review may be conducted by a sampling of at least 50% of such prescriptions. (43-34-103(e.1)(7)(B)). This is more stringent, but similar to the review required by physicians of prescriptions issued by an APRN.

iii. Evaluate/Examine Patients:

Under the previous statute a physician was required to personally evaluate a patient receiving a prescription for controlled substances from a PA at least every three months. (43-34-103(e.1)(6)).

Under the revised statute, a physician must evaluate or examine such patients every three months. (43-34-103(e.1)(6)). This is similar to the oversight required of APRNs.

The revised statute also adds a new requirement that any patient receiving medical services from a PA more than two times in a 12 month period must also be seen by the physician on at least one following visit within the 12 month period. (43-34-109).

e. Limitations

i. Physician Employment:

New language prohibits a physician from being an employee of a PA, however a grandfather provision exempts arrangements approved by the board prior to the effective date of the legislation. (43-34-103(k)).

ii. Abortions:

New language prohibits PAs from performing abortions or issuing, administering or prescribing a drug that will cause an abortion to occur pharmacologically. (43-34-110).