Vanderbilt Law Review

Volume 24
Issue 6 *Issue 6 - Symposium on Legal Paraprofessionals*

Article 6

11-1971

Recent Developments in the Law Relating to the Physician's Assistant

Alfred M. Sadler, Jr.

Blair L. Sadler

Recent Developments in the Law Relating to the Physician's Assistant

*Alfred M. Sadler, Jr.**

*Blair L. Sadler***

I. INTRODUCTION

In his March 11, 1971, address to the National Conference on the Judiciary, President Richard M. Nixon expressed concern about our "overloaded" court system and made several proposals for reform. One proposal advocated greater use of the paraprofessional. Indeed, the President noted: "We should open our eyes—as the medical profession is doing—to the use of paraprofessionals in the law. Working under the supervision of trained attorneys, 'parajudges' could deal with many of the essentially administrative matters of the law, freeing the judge to do what only he can do: to judge."[1] The reference to the medical field is understandable, because the issues raised by the use of lawyer's assistants are remarkably similar to those surrounding the use of physician's assistants.[2] Such questions as motivation, recruitment, dependence/in-

* Assistant Professor, Yale University School of Medicine; Director, Yale Physician's Associate Program; Director, Yale Trauma Program, Department of Surgery.

** Assistant Professor of Law, Yale University School of Medicine; Codirector, Yale Trauma Program, Department of Surgery.

1. N.Y. Times, Mar. 12, 1971, at 18, col. 2.

2. For the purpose of this article, the phrase "physician's assistant" is used as a generic term that includes a wide range of mid-level health workers, including those called physician's associates, Medex, nurse clinicians, pediatric nurse practitioners, and child health associates. There is, however, no consensus in the medical profession on the definition and title of the "physician's assistant." The American Medical Association (AMA) Board of Trustees and its Council on Health Manpower have recommended the following working definition of a physician's assistant: "a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant." Report by the Council on Health Manpower to the Board of Trustees of the AMA (Dec. 1970) (adopted by the AMA). Even if this working definition is accepted, the debate on the proper title of this trained individual will not be ended. Indeed, there is no agreement that one term can satisfactorily describe individuals who have different levels of competence and responsibility. The Board on Medicine of the National Academy of Sciences classified physician's assistants, according to their degree of specialization and level of judgment, as Type A, B, and C. The Report states: "The Type A assistant is capable of approaching the patient, collecting historical and physical data, organizing the data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic steps. He is also capable of assisting the physician by performing diagnostic and therapeutic procedures and coordinating the roles of other more technical assistants. While he functions under the general supervision and responsibility of the physician, he might under special circumstances and under defined rules, perform without

dependence, academic credentials, evaluation of quality, and job mobility are germane to both.

The physician's assistant has been heralded since 1965 as a solution to many of the major problems of today's health care delivery system: the shortage, maldistribution, and overspecialization of physicians; the soaring costs and the poor quality of medical care. Although less than 200 physician's assistants have graduated,[3] more than 100 training pro-

---

the immediate surveillance of the physician. He is, thus, distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment."

"The Type B assistant, while not equipped with general knowledge and skills relative to the whole range of medical care, possesses exceptional skill in one clinical specialty or, more commonly, in certain procedures within such a specialty. In his area of specialty, he has a degree of skill beyond that normally possessed by a Type A assistant and perhaps beyond that normally possessed by physicians who are not engaged in the specialty. Because his knowledge and skill are limited to a particular specialty, he is less qualified for independent action. An example of this type of assistant might be one who is highly skilled in the physician's functions associated with a renal dialysis unit and who is capable of performing these functions as required."

"The Type C assistant is capable of performing a variety of tasks over the whole range of medical care under the supervision of a physician, although he does not possess the level of medical knowledge necessary to integrate and interpret findings. He is similar to a Type A assistant in the number of areas in which he can perform, but he cannot exercise the degree of independent synthesis and judgment of which Type A is capable. This type of assistant would be to medicine what the practical nurse is to nursing." New Members of the Physician's Health Team: Physician's Assistants, Report of the Ad Hoc Panel on New Members of the Physicians Health Team of the Board on Medicine of the National Academy of Sciences (May 1970).

The American Academy of Pediatrics has abandoned the single term and has used "aide," "assistant," and "associate." Other organizations have retained one name, but have chosen one other than "physician's assistant." For example, the National Congress on Health Manpower prefers the term "associate" for those health workers who assume a direct and responsible role in patient care and act as colleagues rather than mere technical assistants to physicians. The congress also noted the term "physician's assistant" often is confused with "medical assistant," which is the title for the nonprofessional office helper who functions in a clerical and technical fashion. National Congress on Health Manpower, Summation of Task Group Reports (Feb. 1971) (sponsored by AMA Council on Health Manpower). Several physician's assistant programs such as those at Yale and Duke, which train individuals to work as colleagues of physicians, have chosen the name "physician's associate." In contrast to this position, the AMA's Board of Trustees rejected the "associate" terminology because it believed "the term 'physician's associate' should be used only to denote another physician." Resolution Adopted by AMA House of Delegates (June 22, 1971) (Atlantic City Annual Convention). Its criticism, however, ignored the " 's," which denotes that the "associate" is not another physician. The World Health Organization believes that such terms as "assistant," "auxiliary," or "aide" are demeaning and should be avoided. 212 WHO TECH. REP. SER. 3, 26 (1961). In line with this criticism, other authorities have suggested such neutral term's as "syniatrist" and "MEDEX." *See* Silver, *The Syniatrist: A Suggested Nomenclature and Classification for Allied Health Professionals*, 217 J.A.M.A. 1368 (1971); Smith, Bassett, Markarian, Vath, Freeman, & Dunn, *A Strategy for Health Manpower: Reflections on an Experience Called MEDEX*, 217 J.A.M.A. 1362 (1971). Until more is understood about effective levels and names, it is not productive to insist upon a hierarchy of titles and a uniform nomenclature.

3. Department of Health Manpower, Division of Medical Practice, American Medical Association, 1971 Survey of Operational "Physician's Assistant" Programs: Numbers Graduated and Employed 1 (Aug. 1971). This figure does not include the graduates of nurse expansion programs.

grams exist[4] and many more are planned. Moreover, a major federal commitment to train physician's assistants has been made. President Nixon has called for fifteen million dollars "for the training of physician's assistants,"[5] all three branches of the armed services are develop-

4. Office of Assistant Secretary for Health & Scientific Affairs, U.S. Department of Health, Education & Welfare, Report on Licensure and Related Health Personnel Credentialing (July 28, 1971) [hereinafter cited as HEW Report]. An examination of a few programs will show the great diversity in this area:

(1) The Duke University "Physician's Associate Program." One of the first major efforts to train physician's assistants was inaugurated in 1965 at Duke University. Returning military corpsmen were taught in a 2-year program to perform a broad range of medical tasks under the supervision and control of practicing physicians. Graduates have been placed in the offices of private practitioners in rural areas, clinics in larger cities, and at the Duke University Hospital. The curriculum consists of 9 months of basic scientific training, followed by 15 months of clinical rotations. This 24-month approach has served as a model for many other programs throughout the country. HEW Report.

(2) The Pediatric Nurse Practitioner and the Child Health Associate. In 1965, a pioneer program to develop a Pediatric Nurse Practitioner was established at the University of Colorado Medical Center. The program provides 4 months of intensive pediatric training for nurses who have completed a baccalaureate nursing program. The Pediatric Nurse Practitioner is allowed to carry out many "pediatric functions" in offices, clinies, and hospitals. A survey of the members of the American Academy of Pediatrics showed that up to 50% of a pediatrician's time is spent on the care and evaluation of the well child, and that much of pediatric illness is routine requiring relatively straightforward treatment. The report concluded that the role of the nurse can be expanded to incorporate much of well-child care and the examination and treatment of simple pediatric illnesses. A second program at the University of Colorado trains high school graduates to be Child Health Associates. The candidate receives 2 years of basic science courses and 2 years of clinical training in a medical school, with heavy emphasis on pediatrics. If an applicant has a bachelor's degree, then he is moved directly into the 2-year pediatric training. Following a one-year internship in pediatrics, the Child Health Associate will be able to practice pediatrics under the direction of a physicians and go considerably further in diagnosing and treating specific illnesses than the Pediatric Nurse Practitioner. The Child Health Associate can, for example, prescribe certain drugs. *See* Silver & Hecker, *The Pediatric Nurse Practitioner and the Child Health Associate: New Types of Health Professionals*, 45 J. MED. ED. 191 (1970); HEW Report.

(3) MEDEX. The MEDEX program at the University of Washington in Seattle trains military corpsmen under the specific guidance of a particular physician, usually with a rural practice, who delivers primary care. The project begins with 3 months of intensive training in the hospital, which includes a review of physical examinations and simple therapeutic procedures. It is followed by a year's preceptorship with a physician, during which the Medex learns to carry out those functions that are most effective in his training physician's practice. To qualify as a preceptor, each physician is carefully screened and agrees to hire his Medex for at least one year after the training period. The MEDEX program is currently being replicated in 5 other states: Utah, North Dakota, New Hampshire, California, and Alabama. HEW Report.

(4) Specialist Physician's Assistants. In addition to programs that train generalists to deliver care in a variety of settings, pilot programs have been developed in San Francisco and Cincinnati to train personnel to work for physician specialists, such as Orthopedists and Urologists. The pilot programs have been received with enthusiasm by appropriate medical specialty boards. *Id.*

(5) The Master's Nurse Clinician. A variety of master's nurse clinician programs are designed to expand the limits of nursing practice to encompass areas traditionally reserved only for the physician. Although these nurse-expansion programs are not officially designated "physician's

ing programs,[6] and the Veteran's Administration has made a major training commitment.[7]

The potential source of physician's assistants is enormous. In addition to the frequently cited Vietnam medic, many highly intelligent, motivated individuals could be attracted to these training programs. For example, in 1970, 24,987 people applied to medical schools although there was space for only 11,348.[8] According to the Association of American Medical Colleges, as many as one-half of the remaining 13,639 were "fully qualified" to become physicians,[9] and many probably would be eager and able to deliver excellent primary health care as a physician's assistant if given the opportunity. Many of the 650,000 registered nurses "in retirement" might be induced back to work by programs offering increased opportunity and responsibility in primary patient care. Other health care professionals, such as pharmacists, inhalation therapists, and laboratory technologists, might see the physician's assistant role as a way out of dead-end career patterns and into more active patient care management.

This article will review the important recent developments in the law relating to the physician's assistant. Special emphasis will be placed on one of the most fundamental and yet complex issues surrounding the physician's assistant—the appropriate scope of his[10] practice.

II. LICENSURE FOR THE PHYSICIAN'S ASSISTANT?

In order to implement fully the physician's assistant concept, the public must be assured of high quality health care and the assistant's functions must be related to those of existing health occupations. Traditionally, quality control has been attempted through the process of state licensure.[11]

---

assistant" programs, they represent analogous attempts to expand the functions of experienced health personnel into direct patient care areas. Nurse clinicians are trained to perform "physician-like" tasks and work under physician supervision. *Id.*

5. N.Y. Times, Feb. 19, 1971, at 16, col. 6 (Health Message).

6. HEW Report.

7. *Id.*

8. Dube, Stritter, & Nelson, *Study of U.S. Medical School Applicants, 1970-71*, 46 J. MED. ED. 837 (1971).

9. *Id.* at 838.

10. Masculine pronouns are used in discussing the physician's assistant. Except for certain programs like MEDEX, *see* note 5 *supra*, which has limited entry to the military corpsman, feminine pronouns would be equally appropriate.

11. Accreditation and certification are also important regulatory mechanisms. Accreditation in the context of this article refers to nongovernmental approval of education and training programs for a health occupation. In the allied health field, accreditation usually is performed by the AMA in conjunction with the particular occupation's professional association. Certification refers to

A Licensing the Physician's Assistant

Although state licensure laws were enacted in the early twentieth century to protect the public from quacks and incompetent practitioners, they are now viewed as unnecessary barriers to educational advancement, effective delegation of tasks, and innovation in manpower utilization. Moreover, the licensure mechanism has failed to eliminate incompetent and unethical practitioners. Consequently, a number of studies[12] and commentators[13] have urged a moratorium on licensure of new health occupations.

The development of different kinds of physician's assistants throughout the country has further complicated the licensure problem. It also has focused particular attention on the thorny issue of a proper legal umbrella for the delegation of medical tasks, because the physician's assistant has been heralded from the beginning as a "dependent" person who would practice only under the supervision and control of a physician. The National Advisory Commission on Health Manpower concluded in 1967 that, "Among the many problems presented by the medical licensure laws, without question, the issue of delegation of tasks

---

nongovernmental approval of persons who meet qualifications specified by the professional association for that occupation. These qualifications usually include completion of an accredited training program and successful performance on an examination administered by the professional group. Licensure, accreditation, and certification may be interrelated to the extent that graduation from an accredited training program is a prerequisite for eligibility to take a certification or licensure examination. In a few instances, licensure may be granted without examination to individuals already certified by their professional association. For an excellent review of accreditation and certification issues see Pennell, Proffitt, & Hatch, *The Role of the Professional Associations in the Regulation of Health Manpower through Accreditation and Certification*, in 1971 NAT'L HEALTH F. 53.

12. Licensure of Health Occupations (Dec. 1970) (Report of the AMA Council on Health Manpower adopted by the House of Delegates); American Hospital Association, Statement on Licensure of Health Care Personnel (Nov. 1970) (adopted by Board of Governors); HEW Report; Report of the National Advisory Commission on Health Manpower (1967). The HEW Report was stimulated by a 1970 amendment to the Public Health Service Act that provides: "The Secretary shall prepare and submit to the Congress, prior to July 1, 1971, a report identifying the major problems associated with licensure, certification, and other qualifications for practice or employment of health personnel (including group practice of health personnel), together with summaries of the activities (if any) of Federal agencies, professional organizations, or other instrumentalities directed toward the alleviation of such problems and toward maximizing the proper and efficient utilization of health personnel in meeting the health needs of the Nation. Such report shall include specific recommendations by the Secretary for steps to be taken toward the solution of the problems so identified in such report." Pub. L. No. 91-519, § 799A (1970 U.S. CODE CONG. & AD. NEWS 1563-78).

13. *See, e.g.*, Forgotson, Bradley, & Ballenger, *Health Services for The Poor—The Manpower Problem: Innovations and the Law*, 1970 WIS. L. REV. 756; Forgotson, Roemer, & Newman, *Licensure of Physicians*, 1967 WASH. U.L.Q. 249; Leff, *Medical Devices and Paramedical Personnel: A Preliminary Context for Emerging Problems*, 1967 WASH. U.L.Q. 332.

is a highly significant, if not the most significant, problem requiring resolution."[14] The report further noted that resolution of this problem would require consideration of the legal regulation and scope of the services of all occupations that render personal health care.

Nearly everyone opposes licensure of the physician's assistant, but there is disagreement as to the appropriate alternative to licensure. After two years of study, for example, a Duke University task force could not agree on which of the following approaches was superior: (1) to codify the physician's authority to delegate tasks to the physician's assistant; (2) to require, in addition, prior approval of training programs by a board, such as the State Board of Medical Examiners; or (3) to require submission to this Board of a job description for the physician's assistant and qualifications of the supervising physician.[15] Others studying this problem have advocated "institutional" licensure whereby the employing institution is totally responsible for the determination of job categories as well as the quality of care.[16] Another approach prefers the licensure of health teams because of increasing acceptance of team delivery of patient care.[17]

B. The Delegation Amendment

Although the doctrine of "custom and usage" has established the authority of physicians to delegate certain tasks, it does not apply readily either to innovations in the utilization of existing health workers or

14. Report of the National Advisory Commission on Health Manpower 332 (1967).

15. M. Ballenger & E.H. Estes, Model Legislation Project for Physician's Assistants (1969) (Department of Community Health Sciences, Duke University).

16. Professor Nathan Hershey describes the operation of this system as follows: "The state hospital licensing agency could establish, with the advice of experts in the health care field, job descriptions for various hospital positions, and establish qualifications in terms of education and experience for individuals who would hold these posts. Administrators certainly recognize the fact that although a professional nurse is licensed, her license does not automatically indicate which positions within the hospital she is qualified to fill. Individuals, because of their personal attainments, are selected to fill specific posts. Educational qualifications, based on both formal and inservice programs, along with prior job experience, determine if and how personnel should be employed." Hershey, *An Alternative to Mandatory Licensure of Health Professionals*, 50 HOSPITAL PROGRESS 71, 73 (1969). One distinct advantage to this scheme is that it would allow the flexible use of licensed manpower in certain approved jobs.

17. In advocating a "team" approach, Ruth Roemer notes that the transition from solo practitioners to a system of health care teams working in organized frameworks is occurring at an uneven rate. She concedes: "It may be, therefore, that two systems of regulating health personnel are needed—one for practitioners to whom patients have direct access and another for practitioners in institutional settings." Roemer, *Legal Regulation of Health Manpower in the 1970's: Needs, Objectives, Options, Constraints, and their Trade-Offs*, 1971 NAT'L HEALTH F. *See also* Carlson, *Health Manpower Licensing and Emerging Institutional Responsibility for the Quality of Care*, 35 LAW & CONTEMP. PROB. 849 (1970).

to new types of personnel, such as physician's assistants.[18] While major conceptual approaches to this problem continue to be debated, several influential organizations have proposed similar solutions. Reports of the American Medical Association (AMA), American Hospital Association, and the Department of Health, Education and Welfare, all recommend that the states enact amendments to their medical practice acts to codify the physician's right to delegate tasks to various types of health personnel who work under his "supervision and control."[19]

1. *State Adoption of Delegation Amendments.*—The legislative delineation of a doctor's right to delegate certain medical tasks began even before the concept had strong organizational support. During the 1960's, four states adopted this solution to provide specific legal recognition for the delegation of tasks. The Colorado,[20] Kansas,[21] and Arizona[22] statutes all permit delegation of medical services to "any person" as long as he is acting at the direction or under the supervision of a licensed physician. The Oklahoma statute is similar, but it was the first to refer specifically to a physician's assistant.[23] As a direct result of the recent widespread proliferation of physician's assistant programs, many other states adopted delegation amendments in 1971. Beyond their similarity in general approach, the statutory language varies considerably. The Utah,[24] Oregon,[25] Washington,[26] Florida,[27] Iowa,[28] New Hampshire,[29]

18. For a detailed discussion of the limitations of the "custom and usage" doctrine in the physician's assistant context see Forgotson, Bradley, & Ballenger, *supra* note 13.

19. *See* reports cited note 12 *supra.*

20. COLO. REV. STAT. ANN. § 91-1-6(3)(m) (1963), permits "[t]he rendering of services under the personal and responsible direction and supervision of a person licensed under the laws of this state to practice medicine or to practice a limited field of the healing arts, but nothing in this exemption shall be deemed to extend the scope of any license. . . ."

21. KAN. STAT. ANN. § 65-2872(g) (1964), exempts from licensure requirements "[p]ersons whose professional services are performed under the supervision or by order of or referral from a practitioner who is licensed under this act."

22. ARIZ. REV. STAT. ANN. § 32-1421(b) (Supp. 1971), provides that the medical practice act does not apply to "any person acting at the direction or under the supervision of either a doctor of medicine or under the supervision of one included in the paragraphs numbered 7 or 8 of this section, so long as he is acting in his customary capacity, not in violation of any statute, and does not hold himself out to the public generally as being authorized to practice medicine."

23. OKLA. STAT. ANN. tit. 59, § 492 (1971) provides that "nothing in this article shall be so construed as to prohibit . . . service rendered by a physician's trained assistant, a registered nurse, or a licensed practical nurse if such service be rendered under the direct supervision and control of a licensed physician . . ."

24. UTAH CODE ANN. § 58-12-40 (Supp. 1971).

25. [1971] Ore. Acts ch. 677 (enacted June 30, 1971).

26. [1971] Wash. Acts ch. 30 (enacted Apr. 8, 1971).

27. FLA. STAT. ANN. § 458.135(2)(d) (Supp. 1971).

28. [1971] Iowa Acts 161, § 1(6) (enacted Apr. 26, 1971).

29. N.H. REV. STAT. ANN. § 329:21 (Supp. 1971).

and California[30] statutes use the term "physician's assistant." In seeking a more inclusive term, North Carolina[31] and West Virginia[32] have used the description "assistant to the physician." Arkansas,[33] Connecticut,[34] and Tennessee[35] followed the Oklahoma designation of "physician's trained assistant," in part at the urging of the AMA.[36] Finally, the New York statute establishes two personnel categories: the generalist—"physician's associate"—and the specialist—"specialist's assistant."[37]

2. *The Permissible Extent of Delegation.*—None of the enacted statutes define delegable tasks or the circumstances under which work may be delegated. Most merely provide that a physician's assistant may "perform medical services."[38] Others refer to the performance of "selected medical tasks"[39] or to "services rendered."[40] These broad and flexible delegation amendments have been acceptable to the public because they all require that the physician's assistant work under the "supervision and control" of a physician. This supervision can occur on at least three levels: over-the-shoulder, on the premises, or remote with regular monitoring and review. It is quite possible that the quality of care with remote supervision can equal that achieved with over-the-shoulder supervision, if the physician's assistant is well qualified and if there is adequate task definition and review. A physician's assistant or nurse practitioner working in a separate location from the physician still could be legally "dependent" because the assistant's actions are subject to continuing medical review and direction.

Typically, the delegation statutes do not define supervision and control,[41] leaving this question, should it arise, to be resolved by the

30. CAL. BUS. & PROF. CODE § 2511(d) (West Supp. 1971).

31. N.C. GEN. STAT. § 90-18(13) (Advance Legislative Service Pamphlet No. 13, 1971).

32. W. VA. CODE ANN. § 30-3A-1 (1971).

33. [1971] Ark. Acts § 72-604 (enacted Feb. 5, 1971).

34. CONN. GEN. STAT. ANN. § 20-9 (1971).

35. TENN. CODE ANN. § 63-608 (1971).

36. *See* Licensure of Health Occupations, *supra* note 12.

37. N.Y. PUB. HEALTH LAW § 3701 (enacted as Bill No. 7073, Mar. 1971). A proposed Minnesota statute, which was defeated, employed the terms "paramedic" and "paramedicine" with the definition of each to be established by a separate committee. Provision also was made for loan preferences to those "medical" and "paramedical" personnel intending to practice "paramedicine" in those areas with a shortage in medical service personnel.

38. *See* notes 25-36 *supra.*

39. *E.g.*, W. VA. CODE ANN. § 30-3A-1 (1971).

40. *E.g.*, CONN. GEN. STAT. ANN. § 20-9 (1971); N.C. GEN. STAT. 90-18(13) (1971) permits the performance of "any act, task, or function" by the physician's assistant.

41. Some statutes, however, are more specific. [1971] Ark. Acts § 72-604(4) (enacted Feb. 5, 1971), for example, requires "direct supervision and control," while Alaska's proposal permits

courts on a case-by-case basis. This approach probably is wise in light of the small number of physician's assistant graduates to date, and the wide variety of settings in which they will practice. Beyond the requirement of supervision and control, however, several states have borrowed an approach from the California statute.[42] They have adopted the additional prerequisite that a person must be a graduate of a program approved by the State Board of Medical Examiners before he can practice as a physician's assistant.[43] The additional safeguard of prior program approval is intended both to provide greater uniformity and to prevent excessive delegation by individual physicians.[44] Furthermore, most of the

"direct communication, when necessary . . . with the physician . . . either by telephone, or any other immediate method" and requires that "the work of the physician's assistant be regularly reviewed by the physician." Alaska House Bill No. 34, 7th Legis., 1st Sess. (1971). [1971] Iowa Acts 161 (enacted Apr. 26, 1971) and N.Y. PUB. HEALTH LAW § 3701 (enacted as Bill No. 7073, Mar. 1971) require physician "supervision and control" but state that this "shall not be construed to necessarily require the personal presence of the supervising physician at the place where the services are rendered." [1971] Fla. Laws ch. 121 (effective July 1, 1971) is particularly restrictive. It provides: "Except in cases of emergency, supervision shall require the easy availability or physical presence of the physician for consultation and direction of the actions of the physician's assistant. . . . A physician's assistant may perform medical services when such services are rendered under the supervision of a licensed physician or group of physicians approved by the board, in the specialty area or areas for which the physician's assistant is trained or experienced. Any physician's assistant certified under this act to perform services, may perform those services only in the office of the physician to whom the physician's assistant has been assigned, where such physician maintains his primary practice, or only when the physician to whom he is assigned is present, or in a hospital where the physician to whom he is assigned is a member of the staff, or on calls outside said office on the direct order of the physician to whom he is assigned."

42. CAL. BUS. & PROF. CODE § 2511(d) (West Supp. 1971).

43. [1971] Fla. Laws ch. 121 (effective July 1, 1971); TENN. CODE ANN. § 63-608 (1971); [1971] Iowa Acts 161 (enacted Apr. 26, 1971); Alaska House Bill No. 34, 7th Legis., 1st Sess. (1971); Mich. House Bill No. 4056 (1971).

44. Most statutes requiring prior program approval give the Board additional authority to draft rules and regulations. For example, N.Y. Rev. Stat. ch. 1136 (1971 NEW LAWS, at 2279) grants the following authority to the Commissioner of Health:

"(1) To promulgate regulations defining and restricting duties which may be assigned to physician's associates and specialist's assistants by their supervising physician, the degree of supervision required and the manner in which such duties may be performed.

"(2) To promulgate regulations establishing such different medical specialities for which specialist's assistants may be registered by the educational department as will most effectively increase quality of medical care available in this state [provided, however, that no category of specialist's assistant shall be established for areas in which allied health professions are presently licensed under education law or public health law.]

"(3) To conduct and support continuing studies respecting the nature and scope of duties of physician's associates and specialist's assistants in order to promote their effective functioning as members of the health care team.

"(4) To determine desirability of and to establish rules for requiring education of physician's associates and specialist's assistants.

"(5) To furnish the education department with suggested criteria which may be used by them to help determine whether an applicant for registration as physician's associate or specialist's

states that have adopted the California "program approval" approach also have limited the number of physician's assistants that an individual physician is allowed to employ.[45]

In our view, the prior approval approach contains major weaknesses. First, prior approval of the *program* misplaces the objective of the review. It does not focus on the kinds of tasks that will be delegated and the situations in which they will be performed. Moreover, excessive weight is given to educational inputs rather than practice outputs, and no assurance is achieved regarding competence of personnel or safety of the patient. Secondly, prior approval transforms the board of medical examiners into an accrediting body. To protect and serve the public, any agency approving these programs—if there is to be such an agency—should have some members with expertise in nonmedical disciplines.[46] Finally, some boards of medical examiners tend to be guild-oriented and often are more concerned with parochial physician interests than societal needs or welfare.

The approach to prior approval taken by the West Virginia statute meets some of these criticisms by requiring the physician's assistant to possess the qualifications that have been established for an approved job description.[47] Approval of a job description and the establishment of qualifications for employment as an assistant to a physician are the responsibility of the medical licensing board. The licensing board, upon submission of a job description, certifies each qualified physician's assistant applicant for employment and also provides for annual renewal of this certification.

---

assistant possesses equivalent edueation and training, such as experience as a nurse or military corpsman, which may be accepted in lieu of all or part of an approved program.

"(6) To adopt such other rules and regulations as may be necessary or appropriate to carry out purposes of this article."

45. Several of the bills prescribe a limit of 2. *E.g.*, [1971] Iowa Acts 161 (enacted Apr. 26, 1971); Mich. House Bill No. 4056, § 15(2) (1971). In contrast, Alaska House Bill No. 34, 7th Legisl, 1st Sess., § 08.64.410 (1971), permits more than 2 physician's assistants per physician "if the remoteness of an area creates a need, as determined by the board, for a greater number of physician's assistants to be supervised by a single physician."

46. Many statutes create an additional committee to advise the medical examining board on the educational aspeets of programs for physician's assistants. Typically, the advisory committee is composed of health professionals appointed by the governor and may include: representatives of the board, representatives of a state medical school, educators experienced in health manpower programming, physicians, and registered nurses. *E.g.*, CAL. BUS. & PROF. CODE § 2519 (West Supp. 1971); Alaska House Bill No. 34, 7th Legis., 1st Sess. (1971); [1971] Iowa Acts 161 (enacted Apr. 26, 1971). Unfortunately, other allied health professions and the public usually are not represented. *But see* N.Y. PUB. HEALTH LAW § 3701 (enacted as Bill No. 7075 Mar. 1971), which calls for the appointment of: "a physician's associate, a specialist assistant, a hospital administrator, a representative of the public, and two persons licensed as allied health professionals."

47. W. VA. CODE ANN. § 30-3A-1 (1971).

III. THE PRACTICE OF MEDICINE AND THE PRACTICE OF NURSING

The further development of the role of the physician's assistant requires a fundamental reexamination of what is the "practice of medicine" and the "practice of nursing." Typically, state medical practice acts provide that no person can "diagnose, operate, treat, or prescribe" unless he is a physician licensed in the state.[48] Except for two programs to be discussed below,[49] these four functions generally remain in the exclusive province of the physician despite the rapid and major advances in health care delivery. Educators, practitioners, and lawyers, attempting to fit dynamic health manpower developments into an archaic legal structure, have been forced to play charades with the law.

A. Defining the Traditional Terms

One obvious problem with state medical practice acts is that the terms "operate, diagnose, treat, and prescribe" usually are not defined.[50] Understandably, the courts have tried to fill this void, but have taken differing views on the meaning of these four concepts. The difficulty in achieving any degree of unanimity is illustrated by surveying the struggle to set the parameters of one of these terms—diagnose. Some courts have held that a nurse's exercise of the responsibility of judging the gravity of symptoms will not constitute an act of diagnosis.[51] Others conclude that when a nurse evaluates a symptom and decides that no serious disease is indicated, she is performing an act of diagnosis.[52] The interpretations of the word "diagnosis" must be examined in relation to the statute in which it appears. Courts properly may construe "diagnosis" broadly if it appears in a statute that prohibits an unlicensed person to

48. *E.g.*, [1971] Ark. Acts § 72-604(4) (enacted Feb. 5, 1971); CONN. STAT. ANN. § 20-9 (1949); W. VA. CODE ANN. § 30-3A-1 (1971).

49. The Child Health Associate Law enacted in Colorado in 1969 allows the Child Health Associate to "practice pediatrics" and to "prescribe" certain nonnarcotic drugs under very specific restrictions. COLO. REV. STAT. ANN. § 91-10-3(2)(a) (Supp. 1969). The new Washington delegation amendment allows a physician's assistant to "practice medicine to a limited extent." *See* note 69 *infra* and accompanying text.

50. The model law, developed by the American Nurses' Association, defines the "practice of professional nursing" as the "observing, care and counsel of the ill, injured or infirm, or the maintenance of health or prevention of illness of others, or the supervision and teaching of other personnel, or the administration of medications in treatments as prescribed by a licensing physician or licensed dentist; requiring substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical and social science." 2 Report of the National Advisory Commission on Health Manpower 439 (Nov. 1967) (sets forth text of model act).

51. *See* Note, *Acts of Diagnosis By Nurses and the Colorado Professional Nursing Act*, 45 DENVER L.J. 467 (1968).

52. *Id.*

hold himself out as being able to "diagnose, operate, treat, or prescribe."[53] On the other hand, public policy has led courts to adopt a more narrow definition of the word "diagnosis" when acts of judgment are being performed by a well trained nurse.[54]

The uncertainty surrounding the term "diagnosis" has been widely recognized in medical literature. A 1966 article concluded that the "inferential or diagnostic task" was central to all nursing practice.[55] The authors noted that traditionally the observational task of the nurse was thought to consist of three activities—observing, recording, and reporting. They accurately state that the observational function now is conceived to be a process that includes: "observation—recognition of signs and symptoms presented by the patient, inference—making a judgment about the state of the patient and/or nursing needs of the patient, and decision making—determining the action to be taken that will be of optimal benefit to the patient. Although all three tasks are cognitive functions, the second and third are clearly intellectual in character."[56] In placing the "inferential or diagnostic task" of the nurse within the boundaries of nursing practice, the authors recognized the need for distinguishing between the functions and responsibilities of the nurse as a diagnostician and the physician as a diagnostician.[57]

The recent development of pediatric nurse practitioner programs provides excellent evidence that the nurse can assume an expanded role in the areas of child health care and can practice a broad range of tasks involving considerable judgment and discretion.[58] These should be recog-

53. *See* Cooper v. National Motor Bearing Co., 136 Cal. App. 2d 229, 288 P.2d 581 (1955). The court concluded that a nurse, evaluating the seriousness of a symptom, was making an act of diagnosis, stating: "A nurse in order to administer first aid properly and effectively must make a sufficient diagnosis to enable her to apply the appropriate remedy. . . . She has been trained, but to a lesser degree than a physician, in the recognition of the symptoms of diseases and injuries. She should be able to diagnose . . . sufficiently to know whether it . . . bears danger signs that should warn her to send the patient to a physician." *Id.* at 238, 288 P.2d at 587. The court was saying, in essence, that in order to administer *first aid*—generally not thought of as the practice of medicine—a nurse had to make a diagnosis. That is, a nurse is making a diagnosis when she decides that no serious disease or symptom is indicated and the patient need not see a doctor.

54. Note, *supra* note 51.

55. Hammond, Kelly, Schneider, & Vancini, *Clinical Inference in Nursing*, 15 NURSING RESEARCH 133 (1966).

56. *Id.* A further significant finding in the work is that the inferential decision and action must at times take place in the span of a few minutes or less. An example of this would be a nurse's work in a coronary care unit.

57. *Id.*

58. Silver, *The Pediatric Nurse—Practitioner Program*, 204 J.A.M.A. 298 (1968). In describing the Pediatric Nurse Practitioner Program developed at the University of Colorado, Dr. Henry Silver states: "Pediatric Nurse Practitioners are able to give total care to more than 75% of all children who come to the field stations, including almost all of the well children (who make up

nized as the functions of diagnosis and treatment.[59] Pediatric nurse practitioner programs may be jeopardized, however, if a recent opinion of the Arizona Attorney General is followed in other states.[60] The Executive Director of the Arizona Board of Medical Examiners, in requesting a formal opinion from the Attorney General, asked:

> What statutory limitations are applicable to the Pediatric Nurse Associate Program, which contemplates the training of registered nurses to perform physical examinations, evaluate health histories and social histories of children and families, counsel parents regarding child development, identify common childhood conditions, advise on management of common childhood illnesses, locate resources within the community to help children and their families, and recognize conditions requiring a referral of children to physicians for further diagnosis and treatment?[61]

After noting that the Arizona Medical Practice Act's delegation amendment permits the delegation of tasks to "any person . . . *so long as he is acting in his customary capacity*,"[62] the opinion states that the Arizona Nursing Practice Act specifically prohibits nurses from "acts of *medical diagnosis, or the prescription of medical therapeutic or corrective measures*."[63] In addition, the opinion observes:

> [I]t is apparent that certain aspects of the proposed functions contemplated for the Pediatric Nurse Associate would violate both the provisions of the Medical Practice Act and the Nursing Practice Act.
>
> While it may be argued that the delegation amendment would permit all of the duties and functions proposed by the question when under the direction or supervision of a doctor of medicine, nevertheless, any duty performed must not be in violation of any statute. . . .
>
> It is recognized that, as a practical matter, delegation of health service functions is to a great extent governed by prevailing custom and practice. In the few relevant court decisions, however, it has been held that a professional custom is no defense to contravention of licensure statutes.

---

slightly more than one half of all patients) as well as approximately half of the children with illnesses or injuries." *Id.* at 299. He also notes that nurses "serve in a variety of field stations" and that, in many of these field stations, physicians only visit the station once or twice a week at which time they see patients with "special problems." *Id.* If the Colorado Pediatric Nurse Practitioner is giving "total care" to a group of patients, "diagnosis and treatment" clearly are part of this process. Dr. Silver avoids the use of these words when he states that the nurse will have "taken a complete history, performed a thorough physical examination, and made a *tentative assessment and evaluation* with particular emphasis on the differentiation of normal from abnormal findings and a preliminary interpretation of the latter." *Id.* at 299-300.

59. A joint statement of the American Nurses Association and the American Academy of Pediatrics (Jan. 1971), dodged the diagnosis question by stating: "The expansion of the nurse's responsibilities should be viewed as increasing the sources from which the nurse gathers data *for making nursing assessments as a basis for diagnoses and action* and thus contribute directly to comprehensive nursing" (emphasis added).

60. Ariz. Att'y Gen. Op. No. 71-30 (Aug. 6, 1971) (on file with the *Vanderbilt Law Review*).

61. *Id.* at 1.

62. ARIZ. REV. STAT. ANN. § 32-1421(6) (Supp. 1971) (emphasis added).

63. *Id.* § 32-1601.5 (emphasis added).

> A review of a joint statement of the American Nurses' Association . . . and the American Academy of Pediatrics, issued in January of 1971, providing guidelines on short-term continuing educational programs for pediatric nurse associates, discloses the following: (1) That the contemplated program has as its purpose the expansion of the nurse's responsibility for making nursing assessments as a basis for diagnosis and action and thus contributing directly to comprehensive nursing; and (2) that nursing practice under the program could involve performance of examinations and assessments therefrom with the capability to 'discriminate' among conditions and 'recognize and manage' minor conditions, while referring more serious conditions to a pediatric physician.
>
> . . . These above procedures are contemplated to transpire in the absence of or prior to the patient seeing a pediatric physician. As such, they are contrary to the prohibitions of medical diagnosis. . . .[64]

The opinion concludes that a Pediatric Nurse Associate may perform the customary professional functions and duties recognized in that speciality if they do not contravene the specific prohibitions of the Medical Practice Act and the Nursing Practice Act. The Attorney General stated: "This opinion is not intended in any way to derogate from the value or service which such a program may provide for the community. However, to fully implement this new program, . . . *certain statutory changes must be enacted to permit these activities.*"[65]

Certainly, the opinion could have defined "acts of medical diagnosis" more narrowly and thus permitted the full implementation of the Pediatric Nurse Associate Program. The limiting phrase "so long as he is acting in his customary capacity" in the Arizona delegation amendment provides less flexibility for a nurse or other health worker to assume expanded responsibility and functions. Since no other delegation amendment contains this limitation, it seems unlikely that a similar construction will be forthcoming from any other court or attorney general.

There is a clear need for major reexamination of the meaning of "diagnosis." Moreover, the above analysis could be repeated readily with respect to "operate, treat, and prescribe"—the other traditional "physician only" functions. Numerous examples of "operating," "treating," and "prescribing," can be found in tasks performed by nurses, and it is clear that physician's assistants will be performing even more of these physician-like tasks.[66]

---

64. Ariz. Att'y Gen. Op., *supra* note 60, at 4.

65. *Id.* (emphasis added).

66. The use of "standing orders" is another game that is played with the law. In effect, standing orders presume to constitute medical direction for the "execution" of medical "decisions" in the physician's absence. Lesnik and Anderson say that "to the extent that orders constitute instructions for cases *already diagnosed*, such orders are valid," but "a physician may not delegate

B. *Recent Statutory Developments*

In recent years, Colorado and Washington have pierced the "only-a-physician-can-practice-medicine veil." The Child Health Associate Law, enacted in Colorado in 1969, defines a "child health associate" as "a person who . . . practices pediatrics as an employee of and under the direction and supervision of a physician whose practice to a substantial extent is in pediatrics."[67] The Act, however, limits the practice of a child health associate to the office of the employing physician and requires the physician to be personally available. The Act also forbids any operative or cutting procedure or the treatment of fractures by a child health associate.[68] The law does set an important precedent by explicitly permitting the child health associate to prescribe nonnarcotic drugs that have been approved by an advisory committee.

In 1971, the State of Washington enacted a law that permits a "physician's assistant to practice medicine to a limited extent under the supervision and control of a physician."[69] The statute provides that supervision and control shall not be construed to require the presence of the supervising physician at the place where services are rendered. The primary restraint in this flexible approach is the requirement that the physician's assistant must be a graduate of a program approved by the State Board of Medical Examiners, which also reviews the competence of the individual physician and the competence and job description of the physician's assistant. Although the broad discretion vested in the Board presents the possibility of abuse, the approach is a fresh and candid one and deserves close scrutiny. The Washington law is an important advance because it recognizes that much of what a physician's assistant does is the practice of medicine.

These developments may help to whittle away at the cliches that have confused scope-of-practice issues. As recently as the September 27, 1971 issue of the *Journal of the American Medical Association*, an editorial cautioned, "State laws provide that only a licensed physician may engage in the practice of medicine and that it is illegal for a physician to delegate the practice of medicine to a person who is not a licensed physician."[70] Such statements are incorrect and out of date in light of

---

the authority to diagnose, to treat, or to prescribe. A standing order for treatment of a headache or a cold is illegal since it presupposes a prescription based on diagnosis." M. LESNICK & B. ANDERSON, NURSING PRACTICE AND THE LAW 281 (1955).

67. COLO. REV. STAT. ANN. § 91-10-3(5) (Supp. 1969).

68. *Id.* § 91-10-3(4).

69. [1971] Wash. Acts ch. 30 (enacted Apr. 8, 1971).

70. 217 J.A.M.A. 1857, 1858. The editorial continues: "On the other hand, it is entirely legal for a physician to use a technician as his 'hands' in work which does not involve a delegation of 'medical discretion.'" *Id.*

recent legal developments and the recognition that the practice of medicine increasingly overlaps other professions.[71] In addition, a 1970 report of the AMA Committee on Nursing concluded that "the same act may be clearly the practice of medicine when performed by a physician and the practice of nursing when performed by a nurse."[72] This description begs the basic need: (1) to recognize certain diagnosing, treating, operating, and prescribing functions for physician's assistants and nurses; and (2) to properly delineate the difference between the tasks that can be performed by physician's assistants and nurses, from those that should be reserved for the physician.

IV. DEPENDENCE/INDEPENDENCE AND EXPANDING ROLES

The dependence/independence issue permeates the entire discussion of the permissible scope of practice for the physician's assistant.[73] The delegation amendments enacted in 1971 did not establish detailed guidelines on this issue, but have allowed the physician's assistant to function in a dependent capacity under a physician, with flexible supervision and control requirements. Under most of these laws, the physician's assistant is authorized to make independent decisions as he "renders service."[74]

71. The 1970 AMA Report on Licensure was surprisingly candid when, in urging states to enact general delegation amendments, it said that such an amendment "would codify the physician's right to delegate, as well as the delegatee's right to participate in the practice of medicine." Licensure of Health Occupations, *supra* note 12, at 6. A graphic example of the misunderstanding of the power to delegate appears in the August issue of *Connecticut Medicine*. The State Medical Society opposed the AMA suggested amendment concluding: "In effect, the bill authorizes physician's assistants to practice medicine without a license, provided that they practice under the supervision of a physician. This will establish a most dangerous precedent, and is not at all equivalent to authorizing Doctors of Medicine to utilize the services of qualified assistants in carrying on and expanding the scope of their medical practices." Legislative Report, *Forewarned Is Forearmed: Governor Signs Physician's Assistant Bill*, 35 CONN. MEDICINE 521 (1971).

72. AMA Committee on Nursing, *Medicine and Nursing in the 1970's—A Position Statement*, in 13 J.A.M.A. 1881 (1970) (approved by the AMA Board of Trustees and House of Delegates, June 1970).

73. One aspect of the dependence issue relates to the method of charging patients for services performed by the physician's assistant. Thus far, the physician's assistant usually has been given a salary and does not receive directly the extra income he generates for the practice. Typically, the patient is charged the same fee whether he is seen by the physician or the physician's assistant. Other arrangements are possible and undoubtedly will be used. Only 2 proposed state laws contain provisions dealing explicitly with the compensation question. The Wisconsin statute provides that "a physician's assistant may not be self-employed" and the Illinois law states that "physician's assistants may not bill patients or in any way charge for services but shall work under the direction of the physician . . . ." Wis. Assembly Bill 707 (Apr. 15, 1971); Ill. House Bill 203 (Jan. 26, 1971).

74. Oregon, however, has taken a stricter approach and declared: "[A] physician's assistant *shall not exercise independent judgment* in determining and prescribing treatment except in life-threatening emergencies." [1971] Ore. Acts, ch. 649 § 3(3) (enacted June 30, 1971) (emphasis added). If this provision is followed literally, it is difficult to imagine certain broadly trained

By taking a legally dependent position, the physician's assistant has been able to assume far more responsibility than he could have if he had attempted to work independently. In contrast to the physician's-assistant focus on dependence, organized nursing has expended considerable effort attempting to define its own independent function.[75] In some cases, this activity has operated to the detriment of expanding its role to include more of the tasks performed by physicians. The striving for an "independent" function and the quest for an enlarged role that includes many medical acts of diagnosis and treatment has been and will be regarded by many as mutually exclusive. Certainly, the public is much more willing to accept the performance by physician's assistants and nurses of medical tasks if they are assured of adequate physician supervision, control, and responsibility.[76] Thus role enlargement and independence often work at cross purposes.

An unfortunate example is the recent experience in New York. A bill was proposed to change the definition of the practice of nursing in the New York State Nursing Practice Act. The proposed amendment read: "The practice of the profession of nursing as a registered professional nurse is defined as *diagnosing and treating human responses* to actual or potential health problems through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restoration of life and well-being, and *executing medical regimens as prescribed* by a licensed or otherwise legally authorized physician or dentist."[77] During the ensuing controversy over the bill the

physician's assistants seeking and finding employment in Oregon. An example is the Type A assistant defined by the Board on Medicine of the National Academy of Sciences. *See* note 2 *supra.*

75. This attempt has been firmly resisted by others. "One of the great difficulties inherent in analytical evaluation of nursing functions has been the reluctance of some professionals to ascribe to professional nursing any authority for the independent performance of any act. Historically, the primary function of nursing was assistance, but the process of gradual assumption by professional nurses of many other functions was inevitable. Without doubt, part of nursing involves the application and the execution of legal standing medical orders and these functions are dependent ones, since performance is contingent upon direction or supervision. But it is widely recognized that this is not the whole of nursing practice. . . . [T]he overwhelming number of functions and the majority of areas of control involve obligations of performance independent of medical orders." M. LESNICK & B. ANDERSON, *supra* note 66, at 261.

76. Dr. Stead has said succinctly: "The physician's assistant can work under a high ceiling and be dependent or under a low ceiling and be independent." E.A. Stead, Dependence vs. Independence and its Relationship to the Professional Physician's Assistant, Third Duke Conference on Physician's Assistants 10 (1970).

77. N.Y. State Senate Bill No. 1918 (1971) (emphasis added). This definition was proposed by the New York State Nurses Association.

complex questions of definition of "practice," "dependence/independence," "supervision," and "control" were debated.

The official bulletin of the New York State Nurses' Association stated that the purpose of the bill was "to delineate clearly the elements of the nursing process and to specify the independence of the *nursing* function."[78] The bulletin said that the old Nursing Practice Act is both obsolete and circular in nature and fails to recognize the nurses' role in the increasingly significant area of health maintenance and teaching. The bulletin continued:

> The changes proposed would in no way infringe upon the interdependent and collaborative relationship between the physician and the nurse, but would simply specify the nurses' authority to diagnose *nursing* needs and administer to those needs through such services as case finding, health teaching, health counseling, and provision of supportive and restorative nursing services or, in other words, to practice nursing . . . . Inclusion within the law of the diagnostic function would authorize the nurse practitioner to make nursing diagnoses, not medical diagnoses. Whereas the diagnosing function as an intellectual process is central to the practice of any number of professionals, including medicine and nursing, the *focus* of this function varies among these professions. For example, the focus in medicine is the nature and degree of pathology or deviation from normalcy; within nursing the focus is the *individual's response* to an actual or potential health problem and the nursing needs arising from such responses.[79]

The legislators were persuaded that the intent of the bill was to define the nurses' own role and not usurp the practice of the physician, and the law was passed by both houses. Governor Rockefeller, however, vetoed it even though he acknowledged the Nursing Practice Act was no longer consistent with modern health practice, and needed to be revised.[80] He thought that the new definition "failed to maintain a responsible distinction between the professions of medicine and nursing commensurate with the respective training and experience of both professions."[81] The veto was strongly supported by the New York State Medical Society, which stated: "The definition of the practice of nursing contained in the above legislation does not accurately reflect the legitimate nursing function. Indeed, the definition is subject to an interpretation *which would result in nurses being authorized as a practical matter to practice medicine*."[82]

---

78. New York State Nurses Association Legis. Bull., No. 4, at 1 (Feb. 16, 1971) (emphasis added).

79. *Id.* (emphasis added). The bulletin expressed criticism of organized medicine asserting: "Medicine views the nurse as a physician's assistant; nursing views the nurse as the patient's assistant." *Id.* at 3.

80. Governor Nelson Rockefeller, Memorandum Filed with Senate Bill No. 1918, July 7, 1971.

81. *Id.*

82. *Id.*

The New York State Nurses' Association responded swiftly and bitterly to this veto. The Association stated:

> Echoing the myopic positions of the Medical Society of the State of New York and the Hospital Association of New York State, the Governor's statement reflects a total lack of understanding of the essential nature of nursing practice and the legitimate role of the nursing profession [because it viewed nursing] *not* as a distinct area of professional practice but simply as a component of the practice of medicine. This view, obviously gives rise to the demand that the definition of nursing reflect the nursing practitioner's *dependence* on the physician.
>
> NYSNA's proposed definition in no way met this demand. On the contrary, for the first time in the history of licensure for nursing, it clearly stated the independence of the nursing function. It was this factor and *this* factor *alone*, which elicited the Medical Society's opposition. . . . Throughout the legislative session the Medical Society advised NYSNA that it *would* accept NYSNA's proposed definition *providing* that the phrase "under the supervision of the physician" were added. Because of our belief that nursing is an independent and distinct profession, such a compromise was totally unacceptable.[83]

At the same time that Governor Rockefeller was vetoing the amendment to the Nursing Practice Act, the New York State legislature passed, and the Governor signed, a law that allowed "physician's associates" and "specialist's assistants" to perform medical services under a doctor's supervision.[84] In discussing relationships between the "physician's associate" and nurses, the Governor stated: "Obviously, if a physician's associate or a specialist's assistant were precluded from doing anything which nurses or other health professionals are authorized to do, there would be little else left for them. While physician's associates and specialist's assistants are not intended to in any way replace existing health professionals, they necessarily will perform many of the same duties."[85] The complex issue of overlapping areas of practice has been turned over to the State Health Department for resolution through regulation.

---

83. Letter from Veronica M. Driscoll, Executive Director of the NYSNA to All NYSNA Members and Groups Concerned with NYSNA's Proposed Definition of Nursing (July 8, 1971) (emphasis in original) (on file with the *Vanderbilt Law Review*).

84. N.Y. PUB. HEALTH LAW § 6532 (enacted in Senate Bill No. 5703, July 6, 1971) provides that the physician's associate must be a graduate of a program approved by the Board of Medical Examiners and "may perform medical services, but only when under the supervision of a physician and only when such acts and duties as are assigned to him are within the scope of practice of such supervising physicians." The specialist assistant "may perform medical services, but only when under the supervision of a physician and only when such acts and duties as are assigned to him are related to the designated medical specialty for which he is registered and are within the scope of practice of his supervising physician." *Id.* § 6532(2).

85. Governor Nelson Rockefeller, Memorandum Filed with Senate Bill No. 7075, July 6, 1971.

V. CONCLUSION

At a time when the entire licensure scheme for regulating health personnel is under widespread attack as being archaic, inefficient, and inhibitive to change, a variety of delegation amendments to state medical practice acts have been enacted as a direct result of the physician's assistant movement. By being willing to remain dependent on physicians and work under their supervision and control, the physician's assistant is able to function under a broad and flexible legal umbrella that allows him to perform to his capacity. This is in stark contrast to nursing and other professions which must expand their roles gradually by custom and usage strategies. The New York nursing law experience provides a vivid example. Focus on the independent nature of the nursing role has resulted in no legislative change and a further widening of the rift between organized medicine and nursing in New York.

Despite the flexibility of the delegation amendments and the rapidity with which they have been adopted, they represent merely a short-term solution to the scope-of-practice problem. Some of the delegation amendments are poorly drawn and contain unnecessary and damaging requirements of prior program approval by boards of medical examiners, which are not equipped to discharge these functions. More fundamentally, they do not come to grips with the underlying need to reexamine the definitions of scope of practice of medicine, nursing, and related health professions in light of medical advances. Certainly, the physician's assistant, the nurse, and other health professionals are performing tasks that come under the traditional medical rubric of diagnose, operate, treat, and prescribe. We need new definitions that will recognize these decision-making judgments and yet delineate clearly those tasks that can be performed only by a physician and that should not be delegated.

Although the problems relating to legal paraprofessionals are somewhat different than the difficulties inherent in the use of physician's assistants, the medical profession's experience has obvious implications. First, it presents a clear warning of the pitfalls that a rigid system of regulation creates. Secondly, it indicates that legal paraprofessionals probably will encounter strong opposition to any attempt to gain an independent professional status. Finally, it suggests the need to reexamine our ideas concerning the practice of law and to redefine this concept in a manner that will enable the lawyer to utilize fully the talents of skilled lay assistants.