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CURRENT STATUS OF THE PHYSICIAN'S ASSISTANT AND RELATED ISSUES

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Current Status of the Physician's Assistant and Related Issues

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Today in the United States, virtually all family practitioners and pediatricians, most internists, and some obstetricians serve as primary-care physicians to patients and their families. Nevertheless, a large number of people are living in areas that can be classified as "medically underserved" in that the services of physicians and other health professionals are not available in proportion to need. The problem is particularly acute in the slum and urban ghetto areas of cities as well as in many rural communities. While it may be true that more physicians are needed, maldistribution and less than optimum utilization of health manpower result from conditions which cannot be treated by simply increasing supply. In fact, the problem may be aggravated by that approach. A preferred approach is to foster more effective use of existing health manpower and to encourage use of new types of allied health personnel where their need has been adequately demonstrated.

Analysis and reorganization of the physician's tasks are now being considered in an attempt to increase his effectiveness. The "physician's assistant" is viewed as one who will provide selected diagnostic and therapeutic services under the direction and supervision of a licensed physician, thereby enabling the physician to render increased services through more efficient use of his knowledge and abilities.

In December 1970, the American Medical Association recommended adoption of the following working definition of the term "physician's assistant":

> The physician's assistant is 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.

There is strong preference within organized medicine for the term "physician's assistant" as opposed to "physician's associate," since the latter term is confusing and commonly implies another physician.

The concept of a "physician's assistant" and the delegation of physician tasks is not new. Physicians have been delegating tasks of all kinds to medical office assistants and nurses for years. What is new is the desire to formalize training within university medical centers to enable a new category of personnel to perform services which extend the physician's capabili-

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ties in the diagnostic and therapeutic management of patients.

Development of the Physician's Assistant Concept

The "physician's assistant" as an alternative manpower resource for extending physician services has become the focus of heightened attention and concern. Interest in training "physicians' assistants" has been primarily stimulated by educators, congressmen, and government officials, and has received further impetus from efforts to utilize the skills of military medical corpsmen returning to civilian life. Although organized medicine was not involved in originating the concept, it must assume responsibility for assuring an orderly and rational development for this new occupation if it is to become a formal adjunct to the delivery of medical care in the United States.

In 1962, Dr. Eugene A. Stead, Jr., then chairman of the department of medicine at Duke University, found in talking with physicians that they were so overworked they were unable to leave their practices to obtain postgraduate education or to enjoy recreational activities with their families. Since it was common knowledge around the Duke Medical Center that highly trained nonphysicians were being effectively utilized to accomplish tasks previously done by physicians, it was thought that such people, with desirable potential and previous experience in the health field, could be trained to serve as intermediate-level professionals. This thinking provided the impetus for the physician's assistant program inaugurated at Duke in 1965 under Dr. Stead's direction. When the program was proposed, the physician's assistant was viewed as "a new category within the structure of the health field designed to provide a career opportunity for men functioning under the direction of doctors and with greater capabilities and growth potential than informally trained technicians." These individuals were to be trained to assist the physician in his clinical or research endeavors in such a way as to facilitate better use of available physicians and nurses.[1]

The Duke program is basically a 24-month curriculum divided into a nine-month didactic portion, and a 15-month clinical portion. Originally intended to provide the general practitioner and general internist with an assistant, the program has expanded to develop assistants for cardiologists, neurologists, nephrologists, rheumatologists, pediatricians, surgeons, radiologists, and others. The program has concentrated primarily on recruiting applicants from the military medical corps, although a male registered nurse, a male practical nurse, and a female practical nurse, and a psychologist have been recruited.[2]

Since the inception of the Duke physician's assistant program, a considerable number of additional programs have been developed throughout the country. The MEDEX program, for instance, which was initiated and first administered by the University of Washington in collaboration with the state medical society, recruits former medical corpsmen who have received formal medical education offered by the military for independent duty. MEDEX training provides three months of didactic study followed by a 12- to 15-month preceptorship under a physician who has expressed a willingness to employ the MEDEX when training is completed. The MEDEX program employs extensive screening of applicants and testing of potential physician-preceptors as part of a careful matching program, to assure realistic and productive relationships between the physician and the MEDEX. Because of the initial success of this program, designed by Richard A. Smith, MD, of the University of Washington, the concept has been replicated in Alabama, California, New Hampshire, North Dakota, and Utah.

The range of additional educational programs being pursued to develop physicians' assistants is partially illustrated by the variety of names used to identify such personnel: clinical associate, child health associate, community health medic, and medical services assistant to name a few. Pilot programs vary in length from five weeks to five years depending on the degree of education and experience required of candidates for admission. In addition to utilizing the background of former military corpsmen, some programs recruit persons with various levels of nursing experience, with experience in another allied health field, or, in some cases, with high school education only. As such, educators are producing many different kinds of medical workers under the generic term "physician's assistant" to function at different levels of responsibility across a wide range of medical fields.[3]

In July 1971, the AMA Department of Health Manpower conducted a survey of 24 nonnursing, nonfederal "physician's assistant" programs identified as operational. Each program was requested to estimate the total number of students graduated as of Dec 31, 1971, and to forward the names and addresses of employers of its graduates. Results of the survey indicate that there would be a total of 184 graduates from all of these programs by the end of calendar year 1971.[4]

Organizational Interest in the Physician's Assistant Concept

The primary concern of the American Medical Association is that services rendered by any level of medical worker be consistent with accepted standards of quality care. In regard to new and emerging categories of allied health personnel, AMA's Council on Health Manpower continues to work closely with medical specialty groups and other professional organizations in applying a rational method to the evaluation of the need for and functions of new categories of health manpower. In 1969, the AMA House of Delegates adopted the Council on Health Manpower "Guidelines for Development of New Health Occupations," which are intended to assist those organizations and institutions contemplating the training and development of new categories of health manpower.[5]

AMA's Council on Medical Education, in addition to maintaining standards for medical education, develops and maintains standards for accreditation of allied medical education programs. It is the accrediting agency for training programs in 17 different allied medical occupations, including the assistant to the primary-care physician and the orthopedic physician's assistant.

The Council on Health Manpower believes that it cannot presume to de-

cide unilaterally on the merits of a particular type of "physician's assistant," but must look to the potential physician employers of such assistants and the organizations representing these physicians for two things: documentation of the need for and readiness to employ these assistants and a detailed job description or list of functions for them. Only with this kind of information can the Council make an intelligent decision whether a proposed new occupation is relevant to health service needs.

Thus far, the American Academy of Orthopaedic Surgeons and the American Urological Association have identified the need for support personnel within their respective areas of medical practice. Both groups conducted independent surveys of their memberships to determine the tasks and functions most appropriately delegated to assistants. The survey results corroborated the need to develop a new type of assistant and laid the groundwork for drafting a comprehensive job description for both the orthopedic physician's assistant and the urologic physician's assistant. Using the AMA "guidelines" the specialty groups prepared documentation for the AMA Council on Health Manpower to review in evaluating the need for and role of these two new health occupations.

The American Society of Internal Medicine, American Academy of Family Physicians, American College of Physicians, and American Academy of Pediatrics have collaborated with the AMA to develop a list of functions that could be delegated to assistants employed by primary-care physicians, especially internists and family or general practitioners. The American Society of Internal Medicine and the American Academy of Family Physicians also completed surveys to document the need for such assistants to be utilized by their members. In endorsing the development of the orthopedic and urologic assistants and the assistant to the primary-care physician, the Council on Health Manpower recommended that the appropriate groups work with the AMA Council on Medical Education to develop educational *Essentials* for the accreditation of training programs. Thus far, "essentials" for the education of the orthopedic physician's assistant and the assistant to the primary-care physician have been ratified by the AMA House of Delegates and are now available for implementation in conducting survey visits to schools applying for accreditation of training programs for these occupations.[6]

The American Academy of Pediatrics has also drafted guidelines for the development of three levels of support personnel: the pediatric aide, the pediatric office assistant, and the pediatric nurse associate. It is estimated that there are more than 25 educational programs being developed to provide special training for the pediatric nurse associate. Although the programs have various titles, eg, pediatric nurse practitioner, pediatric nurse clinician, nurse physician surrogate, they are basically designed to expand the role of the registered nurse in pediatrics to assist in well-baby and child care, patient testing and examination, and health counseling.

The federal government has provided financial support for many of the existing physician's assistant projects. The US Department of Health, Education, and Welfare has assumed a major share of this support through several agencies. Within the Health Service and Mental Health Administration (HSMHA), responsibility for physician's assistant projects is primarily located in the National Center for Health Services Research and Development. Other agencies within HSMHA that support training programs include the Regional Medical Programs Service, Indian Health Service, and Federal Health Programs Service. Additional funding is provided by the Bureau of Health Manpower Education, National Institutes of Health; the Office of Education; the Office of Economic Opportunity; and the Manpower Administration of the Department of Labor.[7]

Early in 1971 the US Civil Service Commission announced the establishment of the physician's assistant as a new occupation within the federal service. Most of the physician's assistant positions thus created will be in hospitals and clinics of the Veterans Administration. Other positions will be in the Public Health Service, the District of Columbia government, and in departments of the military. The US Department of Health, Education, and Welfare states that the physician's assistant in federal service "will be supervised by a medical doctor and will perform designated diagnostic and therapeutic tasks. . . . He will carry out procedures such as taking medical histories, applying and removing casts, and suturing minor lacerations."[8]

The commission has issued qualification standards that specify the level of education and experience required of candidates for positions as physician's assistants in the federal service. Candidates for entry-level positions (GS-7) earning $9,053, typically must have completed a specialized 12-month course of study designed to provide the knowledge and skills required of professional caliber physician's assistants. In addition, the commission's brochure states that the candidate "must have a broad background of knowledge of the medical environment and medical practices and procedures such as would be acquired by a bachelor's degree in a health care occupation such as nursing, medical technology, or physical therapy *or* by three years of responsible and progressive health care experience such as would be obtained by a medical corpsman, nursing assistant, or medical technician."[9] The commission indicates that this requirement has been issued on an interim basis, and that plans for an early revision of this standard "include provision at the level of GS-5 for candidates who have recently completed physician's assistant programs leading to a bachelor's degree."[10]

Qualifications for the next highest level (GS-9) include the requirements listed for GS-7 plus one year of pertinent professional caliber experience comparable to the work of a physician's assistant, or completion of three full academic years in an accredited medical school leading to the doctor of medicine or doctor of osteopathy degree. Qualifications for the GS-11 ($13,309) level also include meeting the requirements for GS-7 plus two years of professional physician's assistant experience, or, completion of all requirements for the degree of doctor of medicine or osteopathy from an acceptable school.[9]

Other than satisfactory completion of the four-page application form, there is no written test; rather the candidate is rated by a panel of medical doctors on the quality and extent of his or her experience, education, and training attained in relation to the knowledge and abilities required to perform the duties of the position. The commission estimates that as many as 500 positions may become available in the federal system.

Potential Duties of the Primary Physician's Assistant

The 1970 report of the Ad Hoc Panel of New Members of the Physician's Health Team, Board of Medicine, National Academy of Sciences, described several types of physician's assistants which it categorized into three levels of functioning, popularly referred to as A, B, and C. These types or levels are distinguished primarily by the nature of the service each is best equipped to render, by virtue of the depth and breadth of their medical knowledge and experience. The report distinguishes the type A assistant from B and C types by his ability to integrate and interpret medical findings on the basis of general medical knowledge and to exercise a degree of independent judgment.[11] According to this classification scheme, specialty physician's assistants, such as the orthopedic and urologic assistants, would function at the B level and medical assistants (office) and practical nurses would function at the C level.

As noted previously, a task force representing the American Academy of Family Physicians, American College of Physicians, American Society of Internal Medicine, and American Academy of Pediatrics was formed in January 1971 to identify appropriate functions for the primary physician's assistant and to develop occupational guidelines.

The assistant described in their joint report is highly skilled in specific aspects of patient care, and corresponds with the highest level of allied health worker, eg, the level "A" assistant defined by the National Academy of Sciences.

The task force report did not address itself to need for or activities of lower technical levels of physician support personnel, but focused only on the assistant to the primary-care physician as a member of the allied health professions who works closely with and under the supervision of the physician (family practitioner, internist, pediatrician) and performs many physician-like tasks.[12]

The assistant to the primary-care physician may be involved with the patients of his employer in all settings of medical care: the office, ambulatory clinic, hospital, patient's home, extended-care facility, or nursing home. His work as defined, however, should always remain under supervision of the physician who retains responsibility for patient care, although the physician need not be present at each activity of the assistant nor be specifically consulted before each delegated task is performed.[12]

The activities of a primary physician in caring for his patients may be briefly classified as follows:

> Diagnostic services in the detection of disease; continuing medical care to include the areas of chronic disease, compensated asymptomatic disease, and pregnancy; care of acute disease and injury, both major and minor; rehabilitation; health maintenance and disease prevention; and health services as may be rendered to the community at large. In rendering these services, the primary physician traditionally performs a variety of activities. Some are essential to his serving the patient and can be performed only by him; these relate to the application of his intellect and skill toward logical and systematic evaluation of the patient's problems, integration and analysis of data necessary for solution of the patient's problems, and use of judgment in planning a program of management and therapy appropriate to the patient. The physician's assistant will assist in gathering the data necessary to reach decisions in implementing the therapeutic plan for the patient.[12]

The tasks performed by the physician's assistant are those which require technical skills, execution of standing orders, routine patient-care tasks, and such complicated diagnostic and therapeutic procedures as the physician may wish to assign to the assistant after he has attained and demonstrated his proficiency through adequate instruction and for whose action the doctor is willing to accept responsibility. The physician's assistant is responsible for keeping complete records of all events and results of encounters with patients, whether by direct contact with patients or by telephone. These entries should be consistent in format and content with the entire record kept on the patient.[12]

The practice of medicine is the responsibility and prerogative of the physician with whom the physician's assistant works. It should be understood by all members of the medical care team and explained to patients that the assistant functions as the agent of his physician employer; that he makes only those decisions and executes only those tasks assigned to him by the physician.[12] The primary physician is responsible for the management of the total and continuing health care of the patient, rather than limited or episodic care, and therefore the physician's assistant will be involved with helping the doctor in the total health care of the patient.

The AMA believes that documentation of need for additional personnel at the national level should be validated by the group representing the potential employers, ie, the medical specialty body (or bodies) whose members will be responsible for utilizing new personnel. At the local level, it recommends documentation be in evidence to indicate that there are sufficient employment opportunities to accommodate the graduates of a program. Additionally, such employment opportunities as exist should not be (1) solely representative of one socioeconomic area, nor (2) primarily concentrated in the parent educational institution. Along these lines, documentation of need might be delegated to areawide comprehensive-health-planning agencies. Additional suggested guidelines for assisting in the development and utilization of physicians' assistants, especially within the hospital setting, have been incorporated in *Answers to Specific Questions on Utilization of "Physician's Assistants,"* available from the AMA Department of Health Manpower.

Acceptance of the Physician's Assistant

Acceptance of the physician's assistant by patients and physicians is reported to be good, according to limited studies by Duke University with the poorest acceptance by patients at the low and high extremes of the eco-

nomic spectrum.[13] The attitudes of physicians concerning the delegation of elements of their practice to trained assistants under supervision indicates acceptance of the concept of the physician's assistant and a willingness to share elements of practice traditionally the prerogative of the physician.

In a survey of 3,425 internists active in patient care, the American Society of Internal Medicine found that its members believed many elements of their practice could and should be delegated to an allied health worker, such as recording elements of the history (60%), home visits (65%), patient instruction (70%), nursing-home visits (43%), and performance of Pap smears (34%).[14] The American Academy of Pediatrics in a survey of 5,799 pediatricians found that over 70% favored delegation of such activities as recording elements of the history and counseling on child care, feeding, and development.[15] More than half believed that an allied health worker should make home visits in follow-up of acute illnesses and for patients with chronic disease and should provide medical advice on minor medical matters. A smaller, but significant, number favored delegating well-child examinations (25%), sick-child examinations (20%), and newborn visits to maternity hospitals (32%).

However, in both of these studies, as well as in one conducted in obstetrics,[16] some discrepancy occurs between what the physician believes he could and should delegate and what he would delegate. These and other surveys revealed that, while 60% may believe that additional help is needed, only 30% would be inclined to hire such additional help for their own practices if such help were available. More than half the pediatricians believed that lack of trained workers is a very serious obstacle to delegation of tasks. The internists indicated that they were equally willing to have patient-care tasks traditionally restricted to the physician carried out by a registered nurse or a physician's assistant, with a slight preference for the physician's assistant in physical examination and patient follow-up and for the nurse in therapeutic activities. Despite the professed willingness to entrust such activities to the nurse, however, delegation is rarely done in the 40% of internists' offices which have a registered nurse.

Education of the Physician's Assistant

The kind of educational preparation that will be adequate and appropriate for training such individuals is currently a subject of much debate among medical and allied medical educators. While supporting the concept of innovation and experimentation in utilizing health manpower, the American Medical Association is concerned with establishing and maintaining educational standards for all levels of personnel who assist the physician in delivering medical services.

Generally speaking, the medical profession believes that clinical affiliation is an essential element of any educational program for the physician's assistant. It is envisioned that clinical training can best be conducted in a model practice unit of a university-affiliated or community teaching hospital. A secondary benefit of locating such programs in clinical teaching centers is the simultaneous education of the primary physician in the techniques of supervision and management of such workers.

State Legislation

Several state legislatures have attempted to deal with the legal status of the physician's assistant in an effort to facilitate utilization. Two regulatory systems for emerging categories of physician support personnel are being developed. Both vest authority in the state board of medical examiners to regulate "physician's assistants" or classes of nonlicensed physician-support personnel trained to perform services in a dependent relationship to physicians. One mechanism provides an exception to the state medical practice act that codifies the physician's legal right to delegate routine patient-care functions to qualified nonphysicians. These states have enacted such exceptions: Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Kansas, North Carolina, Oklahoma, and Utah.[3]

In the following states, legislation has been enacted to empower the state board of medical examiners or other similar agency to (*a*) approve training programs for "physicians' assistants" and (*b*) authorize a physician's use of no more than two graduates of such programs: Alabama, California, Florida, Iowa, New Hampshire, New York, Oregon, Washington, and West Virginia. In the following states, comparable legislative proposals were pending in 1971: Illinois, Indiana, Maryland, Michigan, Minnesota, Nebraska, Ohio, Pennsylvania, Tennessee, and Wisconsin.[3]

A distinctive feature of American education is that the development and maintenance of educational standards has traditionally been the responsibility of national nongovernmental, voluntary accrediting agencies. However the AMA believes that this type of state legislation offers an acceptable regulatory approach to the problem of utilization. The AMA favors mechanisms by which state legislatures, as part of their surveillance, can also qualify physicians to be responsible for the appropriate utilization of physicians' assistants.

Physician's Assistant Credentials

Of particular concern to AMA at this point is the tendency toward proliferation of licensing laws for specific categories of allied health personnel, both existing and emerging. If unchecked, this situation will further accelerate the fragmentation of health-care services, and freeze health occupations into legislatively circumscribed service roles in an era which should be characterized by dynamic innovation and experimentation in health-team functions. In December 1970, the AMA House of Delegates issued a special report on *Licensure of Health Occupations* which reviews some of the acknowledged limitations in current governmental occupational licensing mechanisms, examines some of the suggested changes in, or alternative approaches to, licensing now under consideration or trial, and recommends steps designed to resolve shortcomings in the system, that include the following:

(*a*) a moratorium or holding action on state licensure of any additional health occupations to permit time for study of suggested alternatives to the present system

and development of a workable overall approach to health occupations credentialing;

(*b*) creation in cooperation with other national organizations of a national study commission or task force to develop long-range solutions;

(*c*) a number of steps to effect immediate, short-term alleviation of shortcomings in the present system, including (1) the amendment, where indicated, of existing licensure laws to permit expanded function or task delegation and increased access to licensure or certification for those with other than traditional prerequisites, and (2) expansion of programs for periodically updating and maintaining competence.

The American Hospital Association and American Public Health Association among others have similarly requested moratoriums on state licensing, and planning is underway by the AMA to expedite creation of a national study commission to consider the problems involved.

The Council on Health Manpower is clearly on record as preferring certification to licensure for the emerging health occupations. Evidence is increasing that present licensing laws governing entrance and practice in the allied health occupations do not adequately ensure the selection of competent health-care workers vis-a-vis the exclusion of incompetent ones. Licensing an assistant does not alter the fact that a physician remains legally responsible for the negligent act or omission by an assistant while performing under the supervision of that physician. Moreover, the licensing of additional health-care occupations tends to fractionate the provision of health services, impede job advancement, and hinder employers in utilizing new knowledge and technological advances. In other words, the licensure mechanism inhibits the use of allied health manpower in a safe yet flexible manner at a time when innovation is most desirable. Licensure for new or emerging health occupations would be particularly ill-advised at this point in view of the developmental nature of their service roles.

As there is presently no uniform mechanism for evaluating the physician's assistant's competency to perform on the job, the certification process would offer some assurance of basic competence to the employer and the public. Conducted on a national scale, such a mechanism would assure the physician's assistant the kind of recognition required for geographic mobility. By providing for horizontal and vertical career mobility as the occupation develops, certification does not preclude flexibility in utilization of personnel.

The Council on Health Manpower agreed that such a program, which would grant certification on the basis of nationally validated proficiency examinations to persons of both traditional and unorthodox educational backgrounds, would help to ensure orderly development of the physician's assistant concept under medical guidance. The Council in a special report to the Board of Trustees, and approved by the House of Delegates, recommended that AMA assume a leadership role with appropriate input from other organizations in developing a program to certify the assistant to the primary-care physician, and that appropriate steps be taken to implement this activity.

The focus of the proposed certification program is geared to accommodate the assistant to the primary-care physician (Type "A") who functions as a generalist at the highest level of responsibility. Subsequent certification might very well include medical specialty assistants at the so-called B level.

Basic to the concept of career mobility is the need to evaluate each individual's abilities, regardless of the route he traveled to attain them. The goal of such evaluation is to encourage the advancement of personnel up the career ladder to levels of responsibility commensurate with their knowledge and skills. Proficiency-and equivalency-testing programs can serve as a basis for this evaluation. "Proficiency testing assesses an individual's knowledge and skills related to the actual demands of an occupational specialty or a specific job. Equivalency testing equates learning gained outside of formal training programs with the requirements of courses that constitute recognized formal training programs."[15] Most state regulatory mechanisms for physicians' assistants either in effect or proposed contain a provision for making extensive use of both equivalency and proficiency mechanisms.

An important value of certification to the physician is that it allows him to presume that a certified allied medical employee has basic competence in his or her field, at least until he or she is found to be otherwise. From the standpoint of the worker, such a presumption expedites his employment.

The Physician's Assistant and the Medical Assistant

The medical assistant has become a distinct health care occupation despite some evidence that the career field is not clearly understood. It is estimated well over 200,000 medical assistants now contribute to the supply of personal health services.[16] Confusion regarding the role of the medical assistant has been, in part, due to the following factors: (1) rapid growth of medical assistant training programs, (2) wide use of the medical assistant in many health functions, (3) generalized training given to the medical assistant in a field characterized by growing specialization, and, more importantly, (4) growth and development of the "physician's assistant" concept.

The generic use of the term "physician's assistant" to include all of the diverse educational efforts presently underway tends to create confusion. Moreover, the terms medical assistant and physician's assistant are often used interchangeably in the literature as well as in proposed legislation.

Unlike the physician's assistant, the medical assistant is a well-recognized allied medical occupation. The AMA collaborates with the American Association of Medical Assistants in the accreditation of medical assistant training programs meeting the established standards (essentials). The AAMA also conducts its own certification program on a national basis with guidance from the AMA.

The training of the medical assistant is geared primarily to prepare the individual for employment in a physician's office, although employment is not necessarily limited to that setting. Medical assistants are being utilized in a wide variety of employment settings, including hospitals and large clinics, but it is clear that they are best utilized in a physician's office, where their capabilities can be better applied.[17]

If one assumes that the generalist physician's assistant (A level) func-

tions at a higher level of clinical responsibility than the average medical assistant, there is no reason why the medical assistant should not have the opportunity to move up the career ladder and become a recognized physician's assistant should he so desire. Whatever national program of certification is adopted for the assistant to the primary-care physician it should be sufficiently flexible to accommodate this kind of vertical mobility.

Trends and Prospects

It is difficult to predict the future viability of the "physician's assistant" as a new occupation on a national scale. Many physicians have expressed concern that should such assistants be produced and accepted in large numbers, they may become substitute physicians. The concern inevitably leads to this question: Would such development not result in two levels of care? This issue, as well as those involving the fragmentation of health services, the cost of medical care, liability insurance, and relationships with other professional groups, particularly the registered nurse, will have to be faced by responsible planners and policymakers.

Basically, there is theoretical agreement as to the efficacy of the "physician's assistant" concept as a means of extending physician services, but more consideration needs to be given to such issues as legal status, patient acceptance, physician acceptance, and relationships with nurses and allied health workers before financial support is given to developing educational programs on a widespread scale. The role and function of the "physician's assistant" in the medical care system needs to be better defined, the appropriate educational curriculum clarified, and means adopted to assure that the best standards of education and performance are maintained.

The potential of the "physician's assistant" in the health and medical care system is great; however, the pressures for producing him in increasing numbers and in widely diverse educational settings are already growing so fast that sound thought and action are needed now to prevent the chaos on which the situation is bordering. It is the responsibility of all concerned, and particularly the medical profession, to try to bring about a rational development of physician-support personnel.

The AMA has been working to increase the number of US medical schools and encourage more medical students to enter family practice. Success in these efforts, combined with improvement in medical school curriculum, expanding the role of the nurse, and new technology to automate patient health screening, testing, and monitoring under medical supervision may obviate currently perceived needs for additional categories of physician-support personnel.

Hospitals facing an ever-growing increase in the demand for services should take precautions to assure that "physicians' assistants," if employed by them, do not become free agents, but maintain a close relationship and direct accountability to a particular physician and the medical staff. Organized medicine and the nursing profession should be concerned that all who work as "physicians' assistants," regardless of their backgrounds, have the requisite skills and background to perform in that role. Programs of continuing education should be made available to "physicians' assistants" so they may keep abreast of developments in medicine and technology; additionally, adequate provision should be made for malpractice insurance to cover the services rendered by assistants. Finally, all who have an interest in the development of the "physician's assistant" should be concerned that his duties and functions do not become fixed by law, but are developed under broader principles that permit flexibility in utilization, thereby facilitating the influence of experience.

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