July 26, 1967

MEMORANDUM:

TO: Drs. Sheps, Stead ✓
Geiger, Riessman

FROM: Harry Becker
H.B.

Attached is a typed transcript of the full panel discussions in which you participated at our last spring's health Conference.

Our immediate request is that you supply us with a draft of your comments precisely as you would like them published. If you have already given us a paper for publication you may wish to make changes in it to reflect your thoughts at or subsequent to the Conference. The published proceedings become a reference document used throughout the country. In the past it has been our practice to encourage each author to give us for publication the paper he would like used in the proceedings. In some cases men have wanted to extensively revise their initial comments to reflect the Conference as a whole or to reflect their current thinking at the time of publication.

The Chairman may wish us to publish his introductory comments as well as his summary statement.

We have promised copies to the printer by the first week of September and publication is scheduled for late November. We must keep to this schedule.

As in the past, Dr. Terris and I will prepare a few brief introductory paragraphs for the volume of published proceedings. These will include a summary of Conference highlights also.

If we can make this task easier for you in any way, please call upon us.

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(Start on your page 9)

DR. STEAD: Thank you, Dr. Sheps. I'm going to give you Gene Stead's view of the current world. I am not going to develop each point fully. I am not going to defend each point in depth. But I am going to give you some meat that you can talk about if you wish, or we can go out and walk in the sunshine. I live in a medical school, and therefore my points of reference are the educational programs which supply manpower for the health field. There is a difference between the university whose function is to take green manpower and turn out trained manpower and the health service unit whose function is to give health services with the use of the trained manpower.

Now it is clear you would set up the university and the health service unit in two different ways. A university does research and takes care of sick people in order to develop manpower. We do not do research as a primary interest. Our putput is man. We do not give medical services as a primary interest. Our output again is man.

For the production of the manpower we do use both the tools of research and the tools of medical care and its implementation. I would point out to you that the educational field is of necessity inefficient. You can never educate anybody to think if you are at the same time requiring him to have maximal efficiency in the use of those things which he has already learned. Education is essentially a time in which you put bits of information into people's heads and then you give them the opportunity and the chance to move them around to build new structures, to make new things, and, above all things, to make mistakes.

So, an educational institution by its very nature is an inefficient institution. In the clinical training of manpower, it has to remain in part

inefficient in regard even to use of technical, secretarial and other kinds of help -- for the very real reason that you don't want to raise the basic cost of the unit in which the physician is getting his education to the point where it has to produce the maximal amount of services. If it does, you cannot carry out the education.

It is unfortunate that most of our physicians and nurses go into the areas which are set up primarily for service, where their only experience has been a rather long one in manpower-converting units. When they start to function in primarily a service role, they begin to of course try to create in their service functions exactly what they had when they were in the manpower-converting unit. And, many of the problems which relate to the organization of healthcare, particularly in community hospitals, relates to this frame of reference, which is really, I think, no longer a very good frame of reference when the giving of services is the primary goal.

We believe the time has come for the university system to begin to set up opportunities for an individual who has had his training to work in an area which is concerned primarily with the effective use of trained manpower to give health care. This unit will be a user of trained manpower, not a producer of trained manpower. The university will agree to produce any type of manpower needed by the service area.

Now, of course, in order to do this, one has to have money and one has to have people and one has to have ability. Duke University has given some consideration to this matter. And I will personalize these things because I do not know any other way to be useful to you except to tell you what we are up to. And we decided that we cannot produce manpower and illustrate the proper use of manpower for health services within the existing university unit. We simply cannot make the service unit as a primary goal and function in the

middle of a manpower-converting unit and make it make any sense.

So we are going a distance away from the hospital and, under the direction of Dr. Harvey Estes who is the chairman of our Department of Community Health Services, set up a new building complex. We are going to set up a new faculty and we are going to set up a new fiscal organization, with some monies -- whatever/is accumulated into this venture -- to feed back into the business. Just for raising the money, I think that has gone pretty well. And it will be a few years before we know whether there is any wisdom in this approach to the matter.

I would like to say a word about the names in the health profession. They do get us in trouble. People look on a physician with an M.D. as a kind of a uniform product, when actually you know M.D.s are no longer interchangeable. They have a very wide spectrum of activities, and therefore determining how many doctors there are in relation to population gives you no information at all about the numbers of people who are available for any particular kind of things which physicians do.

Now we are even in worse trouble in regard to nurses. You know if you use the word "nurse" it gives a fairly uniform picture to the physician and to many of the consumers of health care. But, interestingly enough, this picture is quite different from the picture the word "nurse" means to the nursing educator. We would have to say, at least in our part of the world, nursing education is becoming a general form of education. And I would have to say that we have a very attractive student body. They are fun to talk to and to work with. They generally marry well and they live well. But they are no longer a very active force in the health field. And, because of the amount of time which is devoted to general education in the course of the

relatively short half-life of active work in the field, we do not any longer look upon nurses as a primary person allied with the physician who is going to give care in the health field. We are going to have to begin, though, to bring into the health field people who are going to be more closely allied with it and who will, on a career basis, stay with it over a longer period of time.

So, as the whole world changes around us, we are even tripped up by the use of names. I think it is interesting, just as a problem in communication and learning, to see a nursing educator talk to a group of doctors and explain to them that this is general education and is not really closely related to activities in the hospital. Two or three weeks later, ask a group of doctors to give you the gist of what was said. They never remember the part that said that the hospital was no longer the central point in nurses' training.

But I think she has got a perfectly good point and I think we had better hear her. We are at the period of time when new professionals are going to have to be brought into the health field if the physician is able to discharge his duties. I would draw a parallelization again with the nursing field. Some 20 years ago, I think it became obvious that there were not going to be enough nurses to carry out their function in the health field. But it was difficult to get this appreciated, and it was difficult to begin to put in programs which would eventually take up the slack in the nursing field.

The problem is highlighted to me by the fact that the nurse in our hospital is the only person who cannot learn. Now, anybody else in the hospital can be upgraded in their work because they have time to learn something new every year. But our nurses have reached the point where they are in such short supply and are so overcome by their responsibilities that they frankly have no time for learning.

Now, I think this is the same point that is beginning to confront the physician. If you watch the average physician in practice, you discover that he now has little time for learning. As we attempt to give medical care to the entire population, our current supply of physicians is not going to go around. Unless we begin to add more workers to the health field, the physician will find himself within the next 10 to 15 years in exactly the situation in which the nurse is. And for all I know, he may use the same solution -- namely, withdraw as a major factor in the health field.

We do have a difference in point of view between those people who believe the past can be recreated and shored up by tinkering with it here or there, and those individuals who believe that a new era is beginning, an old era is ended, and that not too much time should be spent in tinkering with the shoring up the past. It is clear that I believe one era is ended and another is started.

I would like to say just one word about the problem of putting doctors in relationship to people who haven't in the past received medical care. I was certainly a slow learner in this area. It is easy to learn something in one field and be not able to relate it to what your other hand is doing.

For years we have been concerned with the problem of what to do with people who have come from other countries with a much less well developed society than we have and a much less developed educational system than we have. Frequently they come to this country for college, where they spend four years. They go through four years of medical school. They then go through four or five years of professional training in this country. When they return home they find a society into which they cannot fit and find no niche in which they can be useful. Having made a large emotional commitment to one way of life,

with 12 years of fairly hard work, they tend to be either unhappy where they are or tend to come back here.

We now wish to give modern medical care to a large section of our American citizenry who have received limited care in the past. We have the question of how do we get doctors to them. And it is becoming obvious to us that those bright colored students who compete well in college, who get into the Harvard Medical School and who come to Duke for four years of postgraduate training are not of any help at all to us in this problem. And we are dealing with exactly the same kind of situation we are dealing with when we took other people out of their culture or changed the culture for 12 years and then wished them to go back to it.

So we have begun the slow process of identifying people who have never lost their contact with the culture in which we need help. Under the leadership of Dr. Charles D. Watts, a program has been established at Lincoln Hospital to train Meharrey and Howard graduates. They use the facilities of the Duke Medical Center to give training at Lincoln. Part of the time is spent at the Duke Medical Center. On graduation from the training program, the doctors join the Medical Clinic housed in Lincoln Hospital and take care of both public and private patients. This has converted a totally charitable and somewhat delapidated operation into one that is creating money and new jobs in Durham.

Now, it takes a little bit of time. It takes a little bit of willingness to arrange instructions somewhat differently than we do for our usual graduates, but we have been very pleased with our results. We are not training second-class physicians. We are training physicians in a different way, in a different time pattern, and we are allowing them to begin to create income from practice at a much earlier date than we would a white counterpart in a different social

setting, and we are taking somewhat longer in certain phases of that training.

We are not training scientists, but we are attempting to train doctors who will relate to the community which never before has had medical services. We are beginning to get a flow of physicians to cover an area of our population with good medical care which we've not had before.

In attempting to improve the ability of a doctor to give more services, we have begun to look at the question of how he should be supplied with assistants. We attempted to separate those things the physician does which require judgment from those which require some intelligence and some skill and which were recycled frequently every day. And, as you break down the activities of the physician in this way, it becomes obvious that many things which have been done traditionally by doctors can be done by non-doctors. We were also confronted with the fact that, at this time in history, specialization is with us, and that it is now very difficult for the hospital to produce a pool of personnel trained to fit the many needs of the various kinds and aspects of practice of medicine. It seemed to us that the physician had to define what his needs were, had to find that population which could serve those needs, and to train these people to act as his helpers.

So, beginning on an informal basis some three or four years ago, and on a rather formal basis two years ago, we have begun to train a group of people we have elected to call physician's assistants, and that is exactly what they are. These are people who are recruited by the doctor; they are trained by the doctor; and in the end we intend them to be paid by the doctor.

Of course, we have had the usual kind of problems which you would expect with any new area. We've had the question from nurses as to whether we were stealing things that belonged to them. We've had many questions

from our own intern and resident staff and senior professional staff. Were we going to get in trouble by having people do things done traditionally done by the physicians? Would the assistants eventually set up as doctors? We have had trouble from the hospital administrators who would like the command line to remain -- through nursing service up to the hospital superintendent. They would like for the duties and the financial rewards of this particular group of people to be determined by hospital management rather than by doctors. We have had trouble with government in looking for support because they have said that, in order to work in the health field at any advanced level, you need a college degree. Having been to college myself, I've always been a little skeptical about this thesis. More than a college education, you need dedication to the health field and a willingness to give service, some understanding of why sick people are irrational and why they make demands that well people don't make.

Each year the physician's assistant can learn things he didn't know the year before. This has to be a lifetime commitment. He doesn't work a few years and stop, and a few years and stop, but says, "This is my business", and works at it year in and year out. In the men we have selected for training, the turn of the social wheel has been such that they have only gone through high school and are not financially in a position to go to college. I do not think we would gain anything by sending these men to four years of college, when they have identified they want to be in the health field and are ready to go to work. So we have been in the awkward position of being willing to take high school graduates , which the supporting agencies would not object to if we would give them a very short course. But we are giving them a two-year course which does have in it considerable individualization and is relatively expensive per man. There is plenty of money available to

give short courses to high-school graduates and long courses to college graduates, but we have had trouble in obtaining funds for a two-year course for high-school graduates.

This is an extraordinarily complex nation. North Carolina is very unlike New York City. It's very unlike Montana. I don't think for a minute that the pattern we are setting up of high-school graduates for physician's assistants is a pattern I would urge the country over. I would like to see someone start this at the college level and just find out in general what the products look like who remain longer in the health field and what their various capabilities develop into.

I am not advocating any particular thing except one, and that is I think the old system is ending and that we all ought to be trying out new programs which are possible to start in our own areas. I have talked about men and now I will say a few things about machines. As you know, this is a computerized era, and new ways to handle data are being brought to the health field.

IBM is developing a "clinical decision system", and many of us do believe that data collected by physician's assistants can be fed into the computer before the patient sees the physician. Much of these data can be put together and synthesized by computers.

As this type of machinery comes into being, one must continually reexamine the role of various people who are collecting the data and putting it into the machine. My own guess would be that a great deal of material that is characteristically collected by the physician can be collected by the non-physician and that this can be synthesized in the computer to the point at which the computer can begin to ask questions relevant to the

patient's particular problem. And this is really the point at which the medical practice is the easiest to teach and the easiest to learn. So we have this problem of computer, manpower interface, and what will the machine be like? What will the men be like? Obviously we don't know yet.

Thank you.

CHAIRMAN:

STEAD: The last question is the easiest one to answer. The physician's assistant may want to become a doctor. If he does, he should be required to take the general education and the basic science courses required of the physician. His work as a physician's assistant could count towards the clinical training required of doctors. The amount of credit he could obtain would be determined by an appropriate examination. In practice, a physician's assistant with a family and a high-school education will rarely become a physician. If one trained college graduates as assistants, a larger number would become doctors.

Now, the question of what a physician's assistant should do is one we have not tried to determine. It is perfectly clear that the economics of the situation require that he must do some of the things a doctor has traditionally done. He cannot be used for convenience, just to make life a little easier for the doctor. He has to do things the doctor did and to be paid for those the doctor must then do other things, or there is no worthwhileness in this system.

The point we come to immediately is that the physician has to be trained along with the physician's assistant; otherwise, he really doesn't know how to use him and know what to do with him. Our general plan was to have him have a year of didactic work, which was supervised by the people he is

going to work with. We did not want to farm out biochemistry to the biochemist. We wanted the physician to teach that part of biochemistry which is relevant to current medical practice. Now a physician's assistant has no trouble in determining pH and, statistically, he can move hydrogen ions about the body as well as a doctor three years out of medical school can, because you know those ions quit moving so easily. We have wished him to have some general knowledge of pharmacology but we have not wanted him taught by the pharmacologist. He is taught by physicians who are interested in therapy and the use of drugs. They determine the content of pharmacology. All our doctors haven't liked this because, you know, they have got to take the time to do the teaching. It is always easy if somebody else will do the teaching. But it gives it a different quality and I think, sooner or later, the teaching would wander from where it ought to be. The subjects covered in the first year are the same as those covered in medical school. They are given from a different viewpoint. The second year, we put the assistant in those areas of the hospital which have a high doctor-patient ratio. These include the emergency clinic, admitting room at the VA Hospital, recovery room, respiratory care unit, endocrine clinic, cardiac care unit, group and individual practices in North Carolina, State prison hospitals.

We hope to give our assistant an open-ended certificate and, indeed, this is what we are doing at the present time. The certificate states what we have taught him and what in our opinion he was able to do under the supervision of a doctor. Our terms of contract would be that whenever his doctor or doctors wanted him to do something which would be of benefit to the area in which he works, and for which he needs more training, we would train him. We then amend his certificate and say that now he is competent to do these additional procedures under the supervision of the doctor.

Medical care is a continuum. What you do depends on how much effort you want to spend in learning. A nurse does nothing different from a doctor; a professional nurse does everything a non-professional does, plus additional duties. A man who devotes four years to training will do somewhat less than a man who devotes six years to training. But there is no magic in the system. It just depends on the time commitment you want to make, the time you want to put in before you actually are performing health care on a service basis.

So, all these things can be taught. You progressively can be responsible for/larger area. We don't have a good system of vertical movement in the health field. I am certainly not in a position to throw stones at anybody. The medical profession is as rigid as any other part of this system. A physician's assista-nt should be able to do anything that repetitively re-cycles.

MAN:

GEIGER:

STEAD: I really don't want to fight any wars. As a group, Duke student nurses come from families having a higher income than the families of our medical students. They clearly are pretty, they make good college records. They nurse a few hours a week during a portion of their time at nursing school. And they are excellent mothers and good members of the community. They receive an excellent general education. I have supported colleges all my life. I certainly will continue to support any position our university takes on giving good general education, even if it only peripherally relates to the health field.

Most nurses, when they do work, work at jobs -- as my wife works at a job -- one which she can do and still take excellent care of me. Most of the nurses elect to work in areas such as the airport, where they are not heavily involved in the type of care needed in a busy hospital. I have no objection

to this. I just come back to the fact that an awful lot of the work of the health field cannot be covered by this group.

The reason hospital-centered nurses cannot learn is that there are not enough of them. They cannot be released from the pressing duties of the day for new ventures. They cannot share in the continual learning process of the physician because of lack of time. The availability of time and learning are always related. If we were to have the number of interns drop below a certain level, all the learning would disappear. It takes time, irrespective of the service aspect, to master new kinds of material. And nurses just simply do not have the time in the day to be put aside for learning purposes.

And I think every profession can learn from this experience -- that you cannot get too far behind in the manpower in the jobs you have agreed to cover without then getting into a situation in which you have extraordinarily little flexibility. I did not mean that an individual nurse, given the time to learn, was not able to learn. I meant that the system as now worked -- at least in our part of the world -- in which the numbers have become sufficiently low in regard to the tasks which have to be done -- there is no time to learn what you might like to do the next year or the next year.