The Medical Post

The Maclean-Hunter newspaper for the Canadian medical profession

Do physicians need a new breed of assistant?

ON PAGE 11 of this issue we are publishing the first of a three-part series on the physician associate, that nebulous somebody who is expected to take some of the patient load from the physician's shoulders.

The need to give the physician some relief from his increasing patient load, to reduce dependency on foreign-educated physicians and to streamline the practice of medicine has long been obvious.

In recent months there has been a great deal of talk about the physician's assistant or associate (the job has a number of titles) coming to rescue us in our dilemma of too many patients and too few doctors. The idea has built up until one expects the physician assistant to ride on the scene like the White Knight of the detergent ads. Much of the thinking (and talking) has been just about as sensible as the commercials.

About two months ago we assigned our features editor, Milan Korcok, to take a look at the whole question of more assistance for the physician. We asked him to see if he could sort out the fact from the fiction about the usefulness of the physician's assistant.

Milan Korcok

Was it valid to attempt to train a new type of health worker who would act as the physician's right-hand man? Why had the idea of a new type of assistant emerged at all when the nurse had traditionally occupied that special position? Were the nurses opting out of their role? If so, why? How would these new assistants be paid? What would they do that the nurse does not already do?

In assigning this research into the possibility of a new breed of assistant for the physician we were fully aware the original idea had come from the U.S.A. We asked Korcok to find out what is happening to the idea there. Is it really catching on as some proponents would have us believe? How much of the physician's work is actually being handed over to assistants? What about the training of these people? How much responsibility are the doctors relinquishing? Is the idea a pipedream or is it practical? Will it work in Canada?

Korcok has an incisive, critical mind and his three-part series does not mince words. He concludes that the average primary physician is not making the best use of his time and he blames the physician for some of his own problems. The doctor has never learned to delegate some of his practice functions and is reluctant to let go of any phase of patient care.

Korcok also concludes that the nursing profession has brought much of this cry for a special physician assistant on itself simply by opting out of its original role. The doctors are to blame here too; they have held the nurses to a "fetch and carry" role, not realizing that their best bet for relief from the patient load was already available. It has needed only more communication on both sides. The "Lady with the Lamp" is no longer content with trimming the wick and pouring the coal oil.

Dollars come into this situation. Where do they not? If the physician is going to get more help in his practice — that is, if he is going to turn over some of his present functions to non-medical staff — then a new method of payment must be found. This means changing the legislation governing the provincial health insurance plans. If the changes will mean lower costs and better service for the taxpayer, those changes will be made. Korcok will discuss this factor in the final part of his series.

We feel the series will make a solid contribution to the problem of getting more help for the physician and by cutting through the fuzzy thinking which has added to the confusion. In our opinion the writer takes an objective view of the varying current opinions, comes to practical conclusions which should serve as a sound guideline for future action. — *The Editor.*

(The series appeared in the issues dated Aug. 25, Sept. 8 and Sept. 22, 1970. Reprints of the series are available free. Write to the Editor, The Medical Post, 481 University Ave., Toronto 2.)

Beginning a three-part study of the newest trend in medical manpower

The case for the physician associate

By MILAN KORCOK

PROUD as we may be of our high standards of health care, it is a sad but irrefutable fact that these standards are possible only because Canada is gobbling up students and health professionals from other countries at a prodigious rate.

Though we have given much lip service to the concept of training our own doctors and nurses to serve our own needs, we still tolerate a situation where 55% of the people entering practice in Canada were trained in other countries — many of them with needs far greater than our own.

This precarious reliance on foreign manpower is now forming some hard thinking about how medical resources can be stretched to meet the galloping demands of a growing population. In much of this thinking three alternatives seem to predominate: (1) creating more doctors, (2) distributing the ones we have in a more sensible fashion, (3) making better use of paramedical help.

Since Canadian medical schools are already working at capacity, few plans for new schools are even on the drawing board, and it takes at least 10 years from the time a student enters school until he is functional in society, the first alternative is discounted as an answer to the immediate problem.

As for the second, mandatory or controlled distribution of available doctors seems generally incompatible in a social system that so prizes freedom of the individual.

Consequently the idea of more and better use of paramedical personnel has become a focus of attention by most investigators looking at our medical manpower deficiencies.

A new professional hybrid to free MDs from routine

One of the major investigators in this line is Dr. J. B. Ralph McKendry, assistant professor of medicine at the University of Ottawa, and chief Canadian proponent of the practitioner associate — a new professional hybrid which would theoretically relieve the primary contact physician from many of the routine, repetitive, and grossly time-consuming duties that prevent him from dispensing his real skills.

If there are any experts in this field of the practitioner associate in Canada Dr. McKendry is certainly one of them. He has been writing about this concept for eight years, he has looked closely at the feldsher system in the USSR, at the physician associate program at Duke University in North Carolina, at the nurse practitioner course at the University of Colorado, and at the many variations now developing across the U.S. He was also chief author of the paper on the practitioner associate prepared for the Cost of Health Services Task Force on Manpower, and co-chairman of that committee.

Dr. McKendry has become a key figure in the argument for and against paramedical workers because more than anyone else he has defined exactly what he means by the practitioner associate. His definition has — through his writings and particularly his report to the Task Forces — become the prototype for discussion in Canada.

Dr. McKendry believes strongly in Canada's need to divest itself of medical parasitism: "For very moral reasons we've got to do something." Yet, he admits, that even with herculean efforts we couldn't begin to meet our need for physicians by the end of this century even if we went on a "wartime effort."

But we can relieve doctors of the repetitious chores somebody else with less training can do for less cost.

There is virtual agreement with the proposition that the physician needs this kind of relief. But the consensus breaks down over the idea of developing the practitioner associate as Dr. McKendry suggests: "A new breed of health professional somewhere between the doctor and the nurse."

Primarily Dr. McKendry sees this associate as working directly for the physician on an employer-employee basis with power to diagnose and treat a certain range of conditions under the physician's direct supervision.

It appears everybody has his own idea about what is needed in the way of paramedical personnel, and not everyone in Canada who has looked closely at the situation is willing to accept introduction of a

new cadre of health worker into an already overlapping, complicated superstructure.

The nurses, faced with the prospect of an intruder on what they consider their ground, admit a willingness to fight, as is patently obvious in a recent editorial in *Canadian Nurse:*

"If . . . we are as concerned about patient care as we say we are, we must take a stand on this 'doctor assistant' issue and take it up quickly. Otherwise we may soon find this new category set up and in operation, while we are still trying 'to initiate dialogue with appropriate groups'."

Actually, even the appelation of this new breed is cause for dispute. In the major North American prototype, at Duke University, the name "physician assistant" is used. Other groups use "physician's associate", "nurse practitioner", "medex", "clinical associate", etc.

Dr. McKendry wants a universally-acceptable classification ("Let's have a recognized status . . . and let's not call anybody else that") and he believes "practitioner associate", with the higher inference of status — as opposed to assistant — would better describe the level of function.

Development of the practitioner associate would go far beyond extending community social services or public health or visiting nurse assistance, which many investigators see as a more rational first step in filling the manpower gap.

In discussing development of a practitioner associate Dr. McKendry is piqued by the constant references to the program at Duke. He argues that since it is only four years old and since strict assessment of its products in the field has not yet been made it is getting more publicity that it deserves.

Yet when describing his own proposed Canadian prototype there seem to be very few basic differences in either intent or training.

At Duke, the physician assistant has been drawn primarily from the ranks of military medical corpsmen. Because of the United States' heavy military establishment more than 30,000 corpsmen are discharged annually. Obviously this is a type of manpower pool not available in Canada.

In Canada, nurses would be the primary recruits

In the Canadian context therefore, we have to think of our practitioner associate as being drawn primarily from the ranks of nursing (or from girls who might otherwise consider nursing as a career), possibly from the few qualified ex-servicemen we do have, or to high school graduates with marks not quite high enough to gain them access to medical schools but who might still be willing to serve in a secondary health role.

In Dr. McKendry's view this training would incorporate a four-year course, although previous work in medicine or nursing would count as credits and shorten the course. The formal curriculum might devote about three-quarters of the time to classroom and laboratory teaching and about one-quarter to practical work. Generally the types of practice most likely to benefit from practitioner associateships would be general practice, pediatrics, obstetrics, industrial and military medicine, and institutional psychiatry.

Dr. McKendry believes a university already offering a degree course in nursing science would require little shift in emphasis and curriculum to establish a "practitioner" training institute.

In defining the potential work load of this associate, most of the indicators are once again drawn from the Duke program. Essentially, graduates of this program are viewed as capable of performing some of the skills currently practiced by doctors, nurses and technicians. They may learn to take patient histories, do physical examinations, start and regulate intravenous infusions, intubate the intestinal tract, perform lumbar punctures and other procedures.

The Duke PA is trained to monitor vital signs, give medication and keep progress records — work usually performed by nurses. He is also taught to operate certain diagnostic and therapeutic instruments, such as ECG machines, respirators, cardiac monitors and defibrillators, as well as to carry out some laboratory studies commonly done by technicians.

In the Duke course the first nine months are primarily didactic. Six weeks are spent in lectures in medical terminology, medical history and ethics and basic laboratory procedures. Six months are spent in an integrated series of lectures arranged by organ systems and covering anatomy, physiology, disease states and principles of therapy. During the last half of this period, instruction in history-taking and physical examination is begun. The last six weeks are spent in an introduction to radiology and electrocardiography, plus an introduction to the public health system. The remaining 15 months are spent in a series of clinical rotations.

A program similar to the Duke PA course, called Medex, has been started by the Washington State Medical Association. In this, former corpsmen are given three months of intensive training, followed by a 12-month preceptorship with selected physicians.

A more specialized career program started at San Francisco's Pacific Medical Centre, and City College of San Francisco trains students as orthopedic assistants.

Pediatrics academy fosters three types of assistant

The American Academy of Pediatrics has fostered more programs to date than any other organization within medicine. The academy has defined three categories of health personnel: pediatric nurse

associate (an R.N. whose activities are largely centered on direct patient care), pediatric office assistant (supervised by the physician or nurse associate in such duties as hearing and vision screening and education counselling), and pediatric aide (usually trained on the job after high school graduation, to help the physician, nurse associate or pediatric office assistant in routine or non-skilled tasks).

One sign of the times is that in the United States physicians' assistants have already established a bargaining organization and like other workers it is assumed they will become concerned with salaries and related benefits. At present the starting salary for a physician's assistant is about $10,000.

In Canada there are no similar programs as yet. To see how this concept would work in our system Dr. McKendry would like to se a pilot project set up, optimally with a group of 30 practitioner associates — and field-tested in one province until some results can be established.

In this respect he has some formidable support — from the CMA which has given formal endorsement of such a pilot, from the recommendations within the federal-provincial Task Force reports, from two recent reports prepared in Ontario (by the Council of Health, and the Committee on the Healing Arts), and from the federal Department of National Health and Welfare which has committed itself to providing funds.

But there is also a very formidable opposition by groups who believe there are far better, more practical, and less costly ways of developing the appropriate assistance for the overburdened physician.

A chance to upgrade the nurse's role

By MILAN KORCOK

THOUGH THERE SEEMS to be very little wrong on a theoretical basis with the concept of the practitioner associate, there are great numbers of sceptics who doubt its applicability in Canada at this time.

It is not that Dr. J. B. Ralph McKendry's detractors doubt the need for producing some type of help for the primary contact physician, but they don't believe his very formalized manner of going about it is the right way. Dr. McKendry, assistant professor of medicine at the University of Ottawa, is a leading proponent of associates.

A survey of the critics' thoughts reveals many loopholes in the idea that the practitioner associate, trained four or five years after high school, and working for the primary care physician as an employee is practical. And there are those, of course, who can argue with considerable justification that what we suffer is not a shortage of doctors at all, but a case of poor distribution of doctors.

Despite this line of argument the fact remains that too many Canadians still go without adequate medical care, and whether or not this is due to shortage or maldistribution is in this case academic.

Throughout these arguments at least one common strain shows up time and time again: that the role of aiding a doctor has traditionally been at the core of nursing and there is no reason why a nurse, either with specialty training or just working to the optimum of her training could not regain this function.

This strikes at one of the most salient criticisms of nursing today — the fact that nurses themselves have abrogated their role and have created a void in which the concept of the practitioner associate can nestle cosily.

One physician, a close observer of nursing practices in a large metropolitan hospital, has this criticism of the evolution of nursing — a criticism which has been heard many times over and which seems to have wide support among doctors.

"I have been impressed by the nurses' move away from the medical profession in an attempt to establish some professional status of their own. I have noticed a peculiar reluctance on the part of the nursing school to seek and accept advice regarding the (nursing) profession from the medical profession, including doctors who have a particular interest in the role of nursing in health care.

"When one gets down to the service units, in the doctor's office, in the intensive care units, on the ward, one still sees close cooperation between the doctors and the nurses with the nurses playing the role of the first assistant. As one ascends the hierarchy into administration, nursing school authorities, nursing associations, etc., one encounters this peculiar reluctance to associate closely with the medical profession and a feeling that the nursing profession must 'do its own thing.' Whatever that thing is I am not quite sure.

"The nursing profession faces its greatest challenge and its greatest opportunity to jump into the breach and identify itself as the doctor's first assistant, and to take on the responsibilities that this role implies in community health centres and elsewhere."

This kind of assessment seems particularly apt for Canada because, unlike the United States where there is an excess of medical corpsmen and a chronic shortage of nurses, this country is just now realizing a surplus of nurses, especially in the urban areas.

It is reasonable, therefore, to expect that any development of an assistant for the physician will have to count on the nurse — or the prospective nurse — and will have a considerable impact on the makeup of the nursing profession today.

Though very little has been done on a formal basis in developing nursing programs in this area,

there has been a flowering of informal activity across Canada.

As just one example, Dr. Grant Mills, a family physician in the ambulatory care centre of the faculty of medicine at University of Calgary, is handing over a greater and greater share of his more routine work to a nurse with public health training whom he has in turn trained to assist in his practice.

This nurse does much of the well-baby care, the health instruction and education, longterm management of chronic cases such as diabetics. She even makes house calls.

Though he has used the nurse for only a year so far, Dr. Mills has been able to refer more than 30% of his former workload to her — a figure comparable to that quoted by employers of the physician's assistants in the U.S.A.

Because of provincial medicare regulations, services performed by nurses or other aides are not covered in the same way as services ordinarily performed by the doctor. As a result Dr. Mills makes most use of his nurse in handling those services such as pre- or postnatal care — usually covered by one all-inclusive obstetrical fee. His nurse also takes up about 1½ hours a day with patients on the phone — another area of services for which the doctor wouldn't get paid under medicare.

This phone service allows him to see at least three or four more paying patients throughout the day. For her work, Dr. Mills pays the nurse out of office revenues.

Use of the nurse in an extended role is going to be more formally investigated by Dr. Stanley Greenhill at the University of Alberta in Edmonton. Dr. Greenhill, who has received a federal grant for this specific project, is preparing a pilot scheme to test the role of the nurse and social worker in certain areas of office practice.

At the time of writing, two Vancouver nurses working at the Family Practice Unit at the University of British Columbia are being trained to work side by side with doctors and will soon start taking over many of the physician's duties. The nurses will move freely between patients' homes, report on patients' conditions and generally be encouraged to think and act more independently.

When this program was being instituted several months ago the acting director of UBC's School of Nursing, Elizabeth McCann, said: "In this situation nurses can be challenged to practice nursing to the maximum of their knowledge."

One of the most intensively-studied programs along this line has been the joint project between the Borough of East York Health Unit, the University of Toronto School of Nursing, and six general practitioners, using existing public health and private medical practice arrangements.

Director of this special project, Phyllis E. Jones, associate professor of nursing at the university, has reported extremely satisfying results. She notes that of the referrals made by doctors to the nurses 38% were related to maternity (including nursing supervision postnatally as long as required), 26% were prenatal, and 12% postnatal teaching. The nurses in this project found the prenatal and well-baby referrals particularly satisfying and the patients themselves (or in this case the mothers) avidly accepted their doctor's nurse, and frequently even directed calls right to her.

In maintaining a functional liaison the doctors had to give up only between 45 minutes and one hour per week, time which they believed was more than made up by having the nurse working for them.

The consensus of this group was that significant part of private general practice could benefit from appropriate public health nursing skills. In fact, no new tasks were added to the nurses function except that of working as a colleague to the doctor.

In London, Ont., a study of the use of public health nurses in three different situations has turned up equally encouraging results. In this city nurses have been assigned to the Family Medical Centre at St. Joseph's Hospital, another nurse works with two family physicians, and another nurse works with a group of three family physicians.

To take just one of these situations for example: previously the physician saw the baby at three weeks of age, again at five or six weeks, at eight or 10 weeks, and then at 12 weeks when immunization started. This schedule has now been reduced to visits at one, two and three months of age. The physician has found that his time expenditure in this area of practice has been reduced by 30% to 50%, he has to make fewer phone calls and visits to lessen the anxiety of new mothers.

At the family practice training clinic at McMaster University, nurses trained by the doctors in that unit are absorbing an increasingly large share of the load. But equally important from the point of view of the nurses is that they can now devote themselves entirely to patient care. They appreciate the deep respect they get from patients (as in East York, mothers often call them directly, talk with them much more freely than with the doctor whom they still think of as a "Godlike" figure), and the nurses can spend much more time with the patients which they feel is at the core of what is meant by the nurses' vocation.

"I now get so much satisfaction out of being a nurse . . . of doing the things of which I'm capable . . . of not having to turn to administration to advance or fulfill myself," said one of the nurses candidly.

Development of this nursing adjunct has been so encouraging that the program is going to be extended by appointing a group of four baccalaureate graduates to join the family health unit this fall to work with a group of doctors. This group will be assessed for its adequacy in filling such a role and for determining what additional skills, if any, are needed.

About the only formally-designed course in Canada which prepares a nurse for a solo, independent extended function is the Outpost Nursing Program at the School of Nursing in Dalhousie. The two-year course is available to graduate nurses with one year of experience. It leads to accreditation for complete midwifery, public health nursing, and basic medical and surgical clinic practice.

The purpose of this school is to prepare nurses for independent roles in the remote regions of Canada's north, regions in which the nurse must provide a full spectrum of services while linked to the doctor

only by radio communication.

The program is a five-year pilot scheme now in its third year. It is partially financed by the Medical Services Branch of the federal Department of National Health and Welfare. Of the eight nurses to have graduated so far all are working in the north, six attached to the Medical Services Department. In September 1970, seven students will be entering their second year, and 11 will be enrolled in their first year.

Director of the School of Nursing, Electa MacLennan, is most enthusiastic about the course and the way it prepares the nurses for their work in remote regions.

In an interview with The Medical Post Miss MacLennan also revealed that she has firm hopes the course will be extended to prepare nurses not only for more work in isolated regions but for community health purposes. If this is done, then Dalhousie will have a formalized educational program preparing nurses for the role now envisioned by Dr. McKendry and his supporters as being the province of the practitioner associate.

The only other course in Canada that provides some training for extended work is the advanced obstetrical nursing program at the University of Alberta, but this not nearly so extensive as the Dalhousie program.

In the middle and far north the Medical Services Branch maintains almost 60 nursing stations — physical plants consisting of living quarters, clinical space and beds.

One of the major selling points of the practitioner associate has been his potential service in just such areas. Yet this seems more theoretically viable than it does practical. For one thing the majority of communities requiring service are small, with possibly only 300 persons. Obviously they could not support a clinically-trained person, plus a public-health - trained person, plus a person trained in developing community health. It seems clear, particularly to authorities within the Medical Services Branch itself, that a nurse — particularly the kind being developed at Dalhousie — would be much more suited to this kind of work than would somebody trained by a Duke-type regimen.

Nurses generally feel confident they can handle this job of extended care and that they can do so without changing their designation.

Says Norma Wylie, Director of Nursing at McMaster University: "Taking the nurse, teaching her some extra technical skills and calling her the doctor's assistant is wrong. If it is the nurse who is going to be taught additional skills then I think we should still call her a nurse."

Miss Wylie has given much thought to the expansion of the nurse's role: "It isn't just additional technical skills that should be taught. There is a wide area that nobody is doing very much within the field of patient education, interpretation to the patient and his family, home mental care. In this case it would be helpful to provide some extra preparation in the psychosocial skills, in interviewing techniques, in health teaching techniques, and to also set up a mechanism so the nurse can function much more independently — but still have interdependence with the doctor."

What emerges from this scramble is that the nursing profession's efforts to fill the void some would like to fill with a practitioner associate are scattered, disorganized, done on a "seat of the pants approach". Except from the well-established Dalhousie Outpost program most of the impetus for such exploration is concentrated in family practice units or in offices of privately practicing physicians.

But the ones who are investigating the role of the extended care nurse are coming up with positive results, and this puts them way ahead of the proponents of the formalized practitioner associate concept — who don't even have a discernible pilot program taking shape.

Will a new aide fit Canadian medicine?

By MILAN KORCOK

AT FIRST GLANCE, the idea of training assistants to help primary contact physicians seems perfectly laudable. But practicality often erodes the ideal and there are substantial barriers to be overcome before Canadian medicine can anticipate any benefits from the practitioner associate or even the extended-care nurse.

The first of these drawbacks, related to the cost factor, is the presumption that training a practitioner associate would in fact cost a good deal less than training a full-fledged physician.

One of the best authorities on the subject is Dr. E. Harvey Estes, chairman of community health sciences at Duke University. Dr. Estes stresses that the per annum cost of training the physician assistant "is about the same amount per year as the training of a medical student." He notes that the only real saving of cost is in the fact that the assistant's term of education is shorter.

To date, none of the major pilot projects in the U.S.A., be they related to the physician assistant programs, to the orthopedic assistants, the pediatric nurse assistant, or to the public health nurse projects now under way in Canada, has offered any proof that it could work in a normal community environment, where the patient or his insurance company has to pay the bill for services.

In fact, most of the programs used as models to date have been subsidized by universities or public health units or combinations of both. Therefore they don't really reflect a typical private practice.

In Canada the question must be answered: If a practitioner associate or a nurse provides service to a patient — such as a housecall, or a well-baby examination in the doctor's office — who will pay the fee? At present none of the provincial medicare schemes will pay for services unless they are provided by the doctor himself.

Will the patient be expected to pay for the doctor's assistant out of his own pocket while the doctor's charge is covered by his insurance program? If so will he accept services by the assistant?

One of the most rational solutions to the matter of payments for services by paramedical help seems to be to change the legislation to allow payment for such services, and that payment be pro-rated on the basis of the physician's scale. This would mean that if a certain procedure was done by the assistant, the patient would pay only a certain percentage of the fee the doctor would normally get.

Another major barrier to the development of doctors' assistants is the stringency of most provincial medical Acts which stipulate that only doctors are allowed to provide certain services. In the program at Duke (and according to the criteria being developed for a Canadian practitioner associate) a physician must be fully answerable for the actions of his assistant.

Theoretically this is the case for the many outpost nurses already manning the vast northern areas. Yet, their contact with a physician is often confined to infrequent long distance phone or radio relay calls. Clearly, the doctor cannot provide adequate supervision under these circumstances. However, the government authorities quite logically would not want to make test cases out of such nursing practices since this is the only way Canadians in isolated regions can be served at present.

It seems clear that before a doctor's assistant can be developed, there must be an extensive rewriting of every provincial medical Act in Canada.

One of the major point usually made by opponents of the practitioner associate concept is patient non-acceptance of a "little doctor," "doctor's helper," or second in command. Many have argued that patients who pay their insurance premiums will balk at accepting less than the best.

Yet, surprisingly, experience has shown this line of thinking to be nothing but a red herring.

Judging by both formal and informal pilot programs the patient acceptance of the associate or nurse has been high. In some cases — such as pre- or postnatal counselling — the patient prefers it to the existing association with the physician.

Despite the platitudes and generalities about wanting to be released from routine so they can take on more demanding work, physicians themselves have been remarkably slow in endorsing the concept of the practitioner associate.

In a survey carried out for the British Columbia Health Resources Council by Dr. Hart Scarrow, 46% of all physicians in the sample (25% of all physicians in the province were queried) believed that a medical auxiliary of some kind could be trained to provide relief from the physician's work load. In this survey 53% of the general practitioners felt the idea had merit.

But interestingly enough 56% favored the registered nurse with extended training as the best person to fulfill this role. They further felt that such assistance would be most applicable to the physician in his office, in smaller hospitals without interns, or in semi-independent assistant situations in smaller communities.

Since the physician assistant concept has been developing in the United States for some time, a survey of the attitudes of practicing physicians in one sample state (Wisconsin in this case) is a valuable indicator of how physicians would accept a new brand of assistant.

This particular survey was done by Dr. Robert D. Coye, pathologist, and Dr. Marc F. Hansen, pediatrician, of the University of Wisconsin Medical School.

A questionnaire was sent to the 4,000 members of the state medical society — and 32% responded. Of these, 61% believed that assistants were needed, 42% stated that they would use an assistant in their practice.

Generally, they identified two types of assistants: the hospital technician (serving primarily as an assistant in the hospital surgical areas), and the medical assistant (centering in office practice settings and including taking medical histories, doing technical procedures and assisting with health supervision).

However, when asked to pass judgment on the duties outlined in the existing programs such as Duke, and therefore by projection planned for Canadian trials, the Wisconsin doctors very definitely turned thumbs down.

For example 76% said they would not delegate to such an assistant the power to give anesthetics in routine cases; 69% said they would not refer uncomplicated deliveries; 46% would not allow housecalls; 63% would not allow assistants to do some portions of the physical examinations, such as pelvics; 53% would not allow them to do simple emergency room procedures such as suturing lacerations or extracting foreign bodies, and 43% would not allow them to do routine prenatal checkups.

In fact, about the only things the majority of responding doctors in this survey would allow their assistants to do would be work as surgical assistants in the operating room, take some preliminary histories, and handle technical procedures such as intravenous injections and catheterizations.

It is also significant that in this survey the doctors responding believed quite clearly that nurses (presumably with traditional training) were by far the most urgently-needed assistants. They believed that availability of enough nurses would "damp enthusiasm" for a new group of assistants.

It is clear that physicians in this survey sample see assistants almost exclusively as technicians. Those very duties which are at the core of the physician assistant program at Duke, and in the projections for the practitioner associate concept in Canada, are beyond the scope of the hypothetical assistant in the opinions of the doctors in this survey.

Studies such as these on such a wide scale have

not yet been done in Canada, but impressions can already be gathered from the experimental projects already underway at some of the family practice units.

Dr. Ronald McAuley, at McMaster University Family Practice Clinic stresses that although many doctors pay lip service to the concept of assistants they have shown great reluctance to date in coming forward and actively seeking such personnel for their own practices.

One nurse involved in extended care at such a clinic told The Medical Post that although she does an increasing share of the work load, particularly well-baby care and pre- and postnatal counselling, she has the persistent feeling that the physician to whom she is assigned "just can't seem to let go . . . Though he accepts the value of my work and the concept behind it, he always seems to be hovering. It's not that he doesn't trust me, it's just that he feels so strongly that this is HIS patient."

Guided by such observations the need for educating physicians or at least canvassing them for their needs now seems to be a logical step in Canada, possibly the first step before any pilot is developed.

Another of the major concerns about the development of the practitioner associate is the nature of the job as related to the potential candidate. It is clear that in Canada most of the candidates would be drawn from the ranks of nursing or possibly from among students who are potential recruits to nursing.

But it has also been suggested that high school students who have the sense of vocation but not necessarily the grades might make very good candidates for such positions.

The question many ask: "Would good, worthwhile people be satisfied in a 'cul de sac' job?"

Dr. J. B. Ralph McKendry, of the University of Ottawa, does not believe this would have to be a dead end job. He says that it could provide a spiral through the hierarchy, that it could lead to full medical doctor status even though possibly no more than 20% of those entering this field might be fully-qualified to proceed that far.

"You're going to see some very bright, ambitious people in this kind of role and they won't want to be stuck there. If they have the capability they should be allowed to move up. This would certainly do a great deal to reduce some of the wheel-spinning going on now in the nursing profession."

If such a program got started in Canada Dr. McKendry anticipates most of the recruits would come from nursing, "many of whom are locked in because of the present difficulties of moving upward through the system."

Another basic question: is the person who would be satisfied in a job with such limited potential the kind of person who should be administering such health care?

Dr. A. L. Chute, Dean of Medicine at the University of Toronto, an opponent of the idea of creating a "new breed of cat" puts it this way: "Let nurses, who have the ability and the desire to do so, take a course of training for some particular job. But let them, like specialist doctors, receive recognition and financial rewards for their extra training. And just as specialist doctors are still in fact doctors, let specialist nurses remain nurses. There's no reason to call them anything different.

"This is the real answer. Nursing has to be specialized, and then automatically you've got your doctor's assistant."

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