AN
ABSTRACT
FOR
ACTION

# Nurse Clinician and Physician's Assistant:

## THE RELATIONSHIP BETWEEN TWO EMERGING PRACTITIONER CONCEPTS

PA

Hx

*A Vital Concern in the Reconstruction of our Health Care System*

THE NATIONAL COMMISSION FOR THE STUDY
OF NURSING AND NURSING EDUCATION

*This essay was originally prepared for the Annual Meeting of The Federation of State Medical Boards of the United States, February 12, 1971. It is reproduced here, in slightly altered form, through the kind permission of the* Federation Journal *and its editor, Dr. Ray L. Casterline.*

# PA Hx

## The Nurse Clinician and the Physician's Assistant

In June of 1970, the National Commission for the Study of Nursing and Nursing Education announced the results and recommendations of a three-year investigation of this profession and its relationship to health care in the United States. The impetus for this study can be traced directly to the 1963 report of the Surgeon General's Consultant Group on Nursing which recommended in its final document, *Toward Quality in Nursing*, that there should be an independent examination of nursing with special emphasis on the responsibilities and skills required for high-quality patient care.

In April of 1966, W. Allen Wallis, Chancellor of the University of Rochester, agreed to head such a study if adequate financing could be arranged. The Avalon Foundation, The Kellogg Foundation, and individual benefactors collaborated in the support of the project, and it was officially begun in the fall of 1967 with the appointment of a study staff. The twelve members of the Commission[1] met at periodic intervals over the course of the next two and one-half years, and unanimously agreed on the culminating statement, *An Abstract for Action*,[2] which spoke to the problems of our health system, the pivotal role of nursing in the delivery of care, and the changes that are required in order to make the profession a full contributor to the solution of our difficulties.

In the months since the appearance of the final report, a number of actions have taken place. First, the Kellogg Foundation has enthusiastically agreed to fund an implementation phase to facilitate the adoption of the changes recommended. This has been followed by endorsement of the report by the American Nurses' Association, the National League for Nursing, and the Committee on Nursing of the American Medical Association. Moreover, an *ad hoc* committee named by the American Hospital Association to study the report has reacted favorably to the central thrust of the recommendations and their statement has been accepted for the Association on the recommendation of their General Council. The Conference of Catholic Schools of Nursing,

the New England Board of Higher Education, the Council of Deans and Directors of Southern Regional Education Board's Collegiate Nursing Programs, and the National Federation of Leagues of Practical Nursing are among other professional bodies that have given their support to the Commission report.

These propitious events are not unexpected because the study itself involved literally hundreds of individuals and groups, not only from nursing, but from medicine, health administration, allied health, education, health insurers, and that increasingly vocal body known as consumers—in some other contexts known as patients.

It was the openness and the objectivity of the approaches, further detailed in *An Abstract for Action, Volume II*,[3] that played a vital role in the planning for implementation. Believing both that definite action was required, and that the composition of the Commission should be expanded to facilitate movement, Dr. Leroy E. Burney, then Vice President for Health Affairs at Temple University, and now President of the Milbank Memorial Fund, agreed to accept the Presidency of the Commission for the implementation phase. He was joined by the following new members: Dorothy A. Cornelius, Ohio Nurses' Association; Dr. Joseph Hamburg, The University of Kentucky; Dr. James Haughton, Cook County Hospitals Governing Commission; Dr. C. A. Hoffman, AMA Board of Trustees; Dr. William N. Hubbard, Jr., The Upjohn Company; Boisfeuillet Jones, Emily and Ernest Woodruff Foundation; Mrs. Lois Turner Jones, The Playhouse Academy; Dr. Anne Kibrick, Boston College Department of Nursing; Stuart J. Marylander, Cedars-Sinai Medical Center; Charles S. Paxson, Jr., Hahnemann Medical College and Hospital; Dr. John D. Porterfield, Joint Commission on Accreditation of Hospitals; Mrs. Barbara Resnik, University of California School of Medicine; and Dr. Harold B. Wise, Martin Luther King Health Center.

Six of the original members of the Commission continued on the board: Mrs. Margaret B. Dolan; Marion B. Folsom; Dr. Eleanor Lambertsen; Mary Jane McCarthy; Leonard F. McCollum; and Dr. Ralph W. Tyler. All other former commissioners have agreed to continue service on a National Advisory Council and to remain associated with the general activities of implementation.

This brief background to the Commission and its work will underline the fact that experienced and outstanding individuals from all the health-related fields have joined forces to effect fundamental changes in the practice and educational patterns of the nursing profession.

## The Emergence of the Physician's Assistant Concept

The growth of interest in, and actual development of preparatory programs for, physicians' assistants has closely parallelled the time line of our nursing investigation. It can be reasonably inferred that the underlying problems which caused national concern for the future of nursing also sparked the interest in emerging health occupations. Among the trends that have evoked particular pleas for change are these:

1) *The Rising Need for Care.* A steadily expanding population coupled with increased concern for the inclusion of previously neglected societal segments has brought our entire health care system to the breaking point under sheer "people pressure." Even with a reduction in the birth rate, the increased base will provide vast numbers of new infants who require proportionately more than average amounts of health care. Additionally, the very success of our health care system has increased life expectancy, and, concomitantly, the numbers of our geriatric and domiciliary patients beyond all past experience. Again, these individuals require more than average amounts of care. To meet these demands, it requires little prescience to recognize that we need more hands. It may, however, be important for us to deliberate on what those hands are required to do and how skilled they must be in order to minister to the patients' needs.
2) *The Changed Economics of Health.* Accompanying the rise in demand for care is a fundamental change in the economic structure of our health system. Most analysts agree that, by 1975, 100 per cent of our population will be covererd (for all practical purposes) by some combination of public and private insurance systems. The short and middle-range effects of such a development are bound to increase demands—now fortified with the assurance of prepayment—on an already creaking health system. Add to this the fact that more Americans, encouraged by their insurance for basic care, are spending increasing proportions of their discretionary income on cosmetic or marginal care, and we have the specter of demand almost choking the supply of health care through our present schema.

3) *Growing Interdependence of Care.* If there were no "outside" demands for greater care and greater numbers of care providers, the miracles of medical science would have required a basic reexamination of our staffing and role practices anyway. As Garfield[4] rather clearly documents, we have moved from a relatively simple doctor-patient relationship *(circa* 1900) that embodied most forms of treatment, to a highly complex, interdependent, and increasingly technological system of care. Transplant teams of sixty individuals, cardiac care units with disciplined groups of specialists administering highly technical procedures, new occupations, new disciplines, new equipment—and all interdependent in ways that were not imagined when we built most of our institutions and developed their staffing arrangements.

Little wonder, then, that both physician and layman join in a swelling cry for help. And little wonder that the concept of another care provider is advanced. A care provider who does not have all the skills of a physician; perhaps an individual who has some skills that the doctor does not develop or maintain. A care provider who can be educated more expeditiously, at less expense, and in more institutions than is the physician. Yet, over-all, someone who is competent and humane in dispensing his much-needed services.

The basic question is not whether the physician needs help. He does. The basic question revolves around what kind of help—and by whom. And it is significant to all our concerns that two companion answers have been swelling simultaneously. One answer hinges on the presence of the existing body of American nurses, large in number, already trained in many of the areas that are commonly considered to be paramount to the new practice. A second, competing answer hinges on the development of a new category of personnel, separately named, separately trained. It is in this domain that the report of the National Commission has particular relevance.

## The Paradox of Nursing

It is likely that the confusion of roles and planning begins with the very paradox of nursing itself. For one thing, the public and the health professions, even nursing itself, are conditioned to the existence of a nursing shortage. And these many individuals could scarcely be criticized for neglecting nursing in the consideration of changing roles in

health care if they perceive the profession as being unable to fulfill its own manpower requirements.

As Yett and the other dissenters to the Nurse Training Act Report maintain, however, there is a serious question about the shortage of nurses.[5] It has been reasonably estimated that we produce enough nurse graduates each year to provide an adequate supply of practitioners. Our problem comes first in the distinction between "need" and real economic demand. If Yett is correct, there may be a need for more nurses, but that need is not translated into real demand—otherwise defined perhaps as dollars—which can effectively induce the nurse into continued exercise of skills and training.

The full impact of the paradox of nurse practitioners can be seen by comparing two sets of data. In figure 1, we see the trends in growth rate among nurses and the population as a whole. Not only has the nursing profession increased its overall numbers, but the ratio of nurses to population has increased steadily. In fact, in the period 1950 to 1968, nursing increased from 249 practitioners per 100,000 population to 338 —at a time when medicine was making valiant efforts to increase the supply of physicians and was able to increase the ratio of doctors from 141 to only 150 per 100,000.

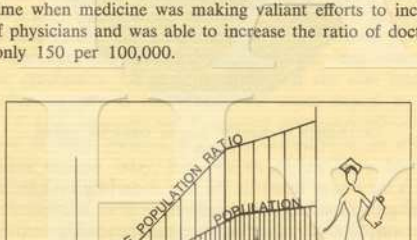


Figure 1

Any enthusiasm over this occurrence is rapidly chastened, however, when we examine the withdrawal rate from the nursing profession. While we have certainly increased the numbers and ratio of nurses in practice, we have suffered sobering losses from the potential numbers

we might have attained. In figure 2, we can see the "staying power" of nurses in professional practice. One out of every four is totally inactive; another 25 percent is active only to the extent of maintaining licensure; of the remaining 50 per cent almost one out of every three is a part-time nurse. Of more than 1,300,000 graduate nurses, approximately 450,000 are employed full-time. This figure, of course, includes nurse educators, administrators, supervisors, and all manner of practitioners.


Distribution of Activity Among Graduate Nurses
Figure 2

Nor is the rate of inactivity the only disturbing evidence of trouble within the profession. Approximately one out of every three students who enter any kind of preparatory program in nursing drop out before completion of their program. Not only do nurses display a greater rate of withdrawal from their profession than any other group of women with similar education and training, but the average rate of turnover among staff nurses in American hospitals is over 70 per cent while the rate of turnover among elementary and secondary teachers—also predominantly female and from the same socio-economic backgrounds—is approximately 20 per cent. Finally, there has been a slow but steady decline in the percentage of high school graduates selecting nursing as an occupational choice.[6]

As indicated by the brief comparisons to other "womens groups" it is inaccurate and misleading to explain these problems by the mere statement that nurses are women and that is that! At the risk of over-

simplification, our three-year analysis of these complex problems wholly corroborated the argument of Hoekelman who proposes, "By any of the criteria which define a shortage of personnel in any occupation, one cannot claim a shortage of registered nurses in this country."[7] *This does not mean, of course, that there is not a need for more practitioners.* It does emphasize that our past approaches to the problems and our assessment of solutions have been naive.

In terms of our present knowledge of industrial and social psychology, it is useful to view the continuation of career performance in terms of a concept of social behavior based on the presence or absence of rewards—in more precise psychological terms, reinforcement. This view, rather than accepting a shortage of personnel as a condition, sees it as a result. And, in terms of the available manpower pool in nursing, this seems a reasonable beginning.

Social psychology would approach the problem in terms like this: the social behavior of nursing is reinforced by a variety of benefits; if the sum total of these benefits is both truly rewarding, and relatively more rewarding than other alternative occupations, then we would expect to find an increased duration of individual activity in the career, reduced turnover, lowered rates of withdrawal, and other evidence of career satisfaction. On the other hand, if the sum total of real, and relative, benefits is inadequate, we would expect to find high withdrawal, high turnover, and frustration symptoms within the occupation and its career patterns. If this last statement is not a description of American nursing today, then, we would not know how to put it into words.

In the light of such an analysis, nursing basically suffers from a lack of sufficiently rewarding conditions. The result is personnel shortage and serious morale problems—neither of which can be resolved until the basic conditions are overcome.

Social reinforcers may be viewed as being either extrinsic or instrinsic to the basic needs of the individual. Extrinsic reinforcers, such as pay and benefits, can provide for the basic survival and security needs of the individual as suggested by Maslow.[8] Such a formulation suggests that until the basic needs of the individual for a living wage and reasonable economic security have been met, it is generally useless to appeal to other motives as a springboard to action. That there are evident economic concerns over nursing compensation is widely recognized. The emphasis of the nursing organizations on economic security, the increasing militancy of bargaining, the develop-

ment of nursing unions, and the growth of the entire "fem lib" salary protest dramatically score the need to provide more reasonable levels—and prospects—of compensation. Parenthetically, however, we would state that economic problems are the most easily solved despite their complexity. Our genius for business in America, and the structure of our modified capitalist society, suggest that we are well geared to handling salary and compensation matters once we identify and really set out to tackle them.

Important as these extrinsic satisfactions are to the individual, Maslow emphasizes that there exists a hierarchy of needs and that each individual has a satiety level for each area of rewards. When this personal satisfaction point is reached, then we must begin to operate with different kinds of rewards. Herzberg[9] is even more emphatic in his consideration of motivational factors because he suggests that certain kinds of rewards are hygienic, merely preventing dissatisfaction, while another group of reinforcers actually produce job and career satisfaction.

The point to conjure with is whether there are indeed some intrinsic satisfiers in nursing that could not only provide a long-range solution to its manpower problems, but contribute to the revitalization of our health care system. The answer may be so simple and direct as to be overlooked. If we examine the abundant evidence of Hughes[10] and others, we will recognize that the primary reason for entering nursing at all is expressed in the desire "to help people." This would suggest in pretty straightforward fashion that the individuals themselves identify as behavioral reinforcers those activities related to direct patient care functions and, very likely, the ability to increase systematically the quality of such personal activity.

If these are the most critical dimensions of intrinsic reinforcement, then we could not have developed a more diabolical approach to frustrating the individual nurse than the present utilization patterns we employ. Christman and Jelinek[11] report after intensive study that registered nurses in hospital situations spend 50 to 75 per cent of their time in non-nursing functions. Their results are confirmed by Duff and Hollingshead,[12] and by many other researchers. In fact, in the analyses we studied of nursing utilization, the RN spent less time in direct patient care than did the practical nurse, the orderly, other types of staff personnel, and the student nurse. We know the temptation is to say: "Well, that's the way they like it." Our reply is that the ones who stay may like it, but most nurses get out of that situation

either entirely or through choosing alternative professional paths.

These alternative professional paths include the movement into nursing education and administration—the recognized positions of power and added compensation. If the frustrations do not drive the nurses away, then the skewed reinforcement system strongly tends to attract them out of practice. And, yet, practice is the primary area of higher intrinsic satisfaction—unless the accumulated testimony of thousands of nurses is to be cast aside without consideration.

It is for these reasons that a first priority of the National Commission, in terms of recommendations, is the re-establishment of practice as the first and proper end of nursing as a profession. For this purpose, we have recommended research into the basics of practice and the development of educational curricula in terms of clinical requirements based on those research findings. Perhaps the Commission philosophy is best summed up in their statement that . . .

> ". . . nursing career patterns should be so organized that recognition, reward, and increased responsibility . . . are based on increasing depth of knowledge and demonstrated competence to perform in complex clinical situations."

In short, it is absolutely imperative that we re-direct the reinforcement schema in nursing from rewarding non-practice activities to rewarding those actions most closely related to the intrinsic satisfactions that induce persons into the profession initially. And this is not suggested for the purpose of "making the nurses happy," but as a cold, hard design to ensure that our health care system remains viable.

## Relationship to the Physician's Assistant

We assume by this point that the relationship between the Commission recommendations and the rising interest in the physician's assistant is close and direct. If the physician's assistant becomes, in fact, a foreclosure on the development of increased, enhanced role functioning in nursing then we think we are making a very serious mistake in terms of the long-run needs of the country. And we would hazard to suggest that it will be a serious mistake for the profession of medicine as well as nursing and the health system generally.

The chairman of the AMA Committee on Nursing, Dr. Charles Leedham, points out: "The nurse is the logical individual to support the physician in the management and care of the patient. This support is broadened as nursing moves into the age of specialization. This

thrust toward an expanded role supports the desire expressed by the nursing profession for more significant role responsibilities. An enhanced role for the nurse will enable the physician-nurse team to better meet the challenging demand for more adequate delivery of health care to the entire population."[13]

Proceeding on the simple facts that: the nurse has historically been the physician's first assistant since 1900; that nursing represents the largest single body of prepared health practitioners in the country; and that nurses are forcefully expressing an interest in enhanced role practice in both episodic and distributive settings, it seems only rational to plan jointly before we once more recapitulate the fatal cycle of setting up one more health occupation that must fight for its place in the sun by coopting the functions and techniques of its related functionaries.

It is strange, indeed, that we show so little willingness to learn from the experience of those whose professional study is the examination of organizational effectiveness. At the very time we in the health sector are emphasizing the development, nay proliferation, of more and more occupations of more and more limited scope, the people who have examined the scientific management model in business and industry (over a much longer period and under more controlled conditions than we in the health professions) are rejecting such approaches for the opposite concept of job enlargement. And we know of no more apt way of describing both the natural desires of nursing, and the requirement for developing the environment for intrinsic motivation, than to label it as "job enlargement."

Now, it may be that our concerns over the physician's assistant are entirely groundless. That is, the new occupation may not function to stifle the natural development of the nursing role and the career perspective of that profession. As a matter of fact, the variety of programs labeled as preparatory for the physician's assistant makes it difficult for us to analyze precisely what we mean by the term. But this brings us to the point that the public interest, the need for interdependence in professional role performance, and our own need to function effectively argue against another experience of "muddling through" the problem. To this end, the National Commission has a proposal that we think is critical for all our sakes. The Commission recommends that we begin to think and plan first, then act in accordance with consensual decisions. Specifically, we propose that:

"A National Joint Practice Commission, with state counter-

part committees, be established between medicine and nursing to discuss and make recommendations concerning the congruent roles of the physician and the nurse in providing quality health care with particular attention to the rise of the nurse clinician; the introduction of the physician's assistant; the increased activity of other professions and skills in areas long assumed to be the concern solely of the physician and/or the nurse."

This specific proposal, central to the thrust of the report as a whole, has been endorsed by both the ANA Board of Directors and the AMA Board of Trustees and represents a viable alternative to the growth of occupations "like Topsy." A beginning has been made in implementation of this recommendation through the joint committee of the AMA-ANA-NLN, but more specific attention must be given to the congruent role concerns of the practitioners—and that should be the province of a newly appointed Joint Practice Commission. A beginning has already been made through joint agreement of the ANA Congress for Nursing Practice and the AMA Committee on Nursing. From their cooperation can come the foundation of the national Joint Practice Commission.

Through national and state counterpart committees we can begin to resolve the functional and jurisdictional problems that have beset us for too long—and hopefully prevent their proliferation and reoccurrence. Let us emphasize in this regard that we do not anticipate that such commissions would necessarily reject the concept of the physicians' assistants. Rather, we would hope they could better clarify the roles of such a person, determine whether such an individual needs to be developed *ab initio* or can be drawn from established manpower pools, and outline the relationships of such a person to related role performers.

## Related Administrative Matters

While we wait—and we use that term emphatically—for concerted proposals from the Joint Practice Commissions for the future development of congruent roles and professional responsibilities, the Commission feels strongly that we should retain our current licensing regulations in nursing, that is, a single license attesting to minimal skills for safe beginning practice. The certification of advanced clinical practice, specialization, and other recognized levels of professional competence should for now be left to professional—or inter-professional—

boards. We recognize that the decisions which come from the Joint Practice Commissions will have a decided impact on the health practice laws of the several states since it seems inevitable that nursing will assume both more responsibility and liability for individual practice in all kinds of settings. We have already had experience in more than half the states with the formulation of joint statements on practice which have affected either state practice acts, or their specific interpretation. Likely, the emergent roles will require more fundamental reconstruction of governing legislation than can be accomplished by simple amendment or rulings.

This, however, we recognize as the forte of the state practice boards. And it is presumptuous of us to enlarge upon it. Suffice it to say that the State Medical Boards can be decisive in the development of new and congruent roles between the two oldest health professions—not for the purpose of barring the development of new occupations—but to ensure orderly, rational, and effective emergence of needed health practitioners in place of a proliferation of idiosyncratic role developments.

## FOOTNOTES

1. The original Commission included: Ray Everett Brown, Executive Vice President, Northwestern University Medical Center; Dr. Lowell T. Coggeshall, former Vice President, University of Chicago; Margaret B. Dolan, Head, Department of Public Health Nursing, School of Public Health, University of North Carolina; Marion B. Folsom, former Secretary of Health, Education, and Welfare; Walter E. Hoadley, Executive Vice President, Bank of America National Trust and Savings Association; Dr. Eleanor Lambertsen, Dean, School of Nursing, Cornell University; Dr. Herbert E. Longenecker, President, Tulane University; Mary Jane McCarthy, Director, Nursing Service, Veterans Administration; Leonard F. McCollum, Chairman of the Board, Continental Oil Company; Dr. Robert K. Merton, Giddings Professor of Sociology, Columbia University; Dr. Ralph W. Tyler, former Director, Center for Advanced Study in Behavioral Sciences, Stanford University; W. Allen Wallis, President, University of Rochester.
2. *An Abstract for Action*. National Commission for the Study of Nursing and Nursing Education. New York: McGraw-Hill Book Co., 1970. 167 pp.
3. *An Abstract for Action, Volume II, Appendices*. National Commission for the Study of Nursing and Nursing Education. New York: McGraw-Hill Book Co., 1971. 509 pp.
4. Garfield, Sidney R. "The Delivery of Medical Care," *Scientific American*. 222:4:15–23, April, 1970.
5. Yett, Donald E. "The Nursing Shortage and the Nurse Training Act of 1964." *Industrial and Labor Relations Review*. 29:1:200, January, 1966.
6. See also: "A Guide for Establishing Statewide Joint Practice Commissions." The National Commission for the Study of Nursing and Nursing Education. Rochester, N. Y. 1970. (pamphlet).
7. Hoekelman, Robert A. "Florence's Fable." *Newsletter of the Ambulatory Pediatric Association*. 5:2:23, February, 1970.
8. Maslow, Abraham. *Motivation and Personality*. New York: Harper and Brothers, 1954.
9. Herzberg, Frederick, Bernard Mausner, and Barbara Snyderman. *The Motivation to Work*. New York: John Wiley & Sons, 1959.
10. Hughes, Everett *et al. Twenty Thousand Nurses Tell Their Story*. Philadelphia: J. B. Lippincott Company, 1958.
11. Christman, Luther P. and R. C. Jelinek. "Old Patterns Waste Half the Nursing Hours." *Modern Hospital*. 8:1:79, January, 1967.
12. Duff, R. S. and A. B. Hollingshead. *Sickness and Society*. New York: Harper and Row, 1968.
13. "Officially Speaking. . .", *RN Magazine*, 33:10:57–, 82–90.

Inquiries and correspondence should be addressed to:

Dr. Jerome P. Lysaught, *Director*
National Commission for The Study of Nursing
and Nursing Education
208 Westfall Road
Rochester, New York 14620