SCIENCE · ORGANIZATION · SERVICE · EXCELLENCE

The Internist

TEACHER · CONSULTANT · SPECIALIST · PERSONAL PHYSICIAN

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CPT ADOPTIONS INCREASE

Michigan State Medical Society Council

Rhode Island Medical Society House of Delegates

Massachusetts Medical Society Council (House of Delegates)

North Carolina Blue Shield

The Councils and/or House of Delegates of these Societies recently took action to approve resolutions adopting the AMA's *Current Procedural Terminology* as ". . . the best listing of coding and medical procedures available . . ." and ". . . the basic language for all medical and surgical procedures in the future."

North Carolina Blue Shield communicated to the NCSHM its acceptance of CPT and its intention to process it by hand until their computers can be converted to the five-digit code.

The above is in addition to the number of CPT adoptions already reported in the August issue of *The Internist*.

Watch future issues for further news on CPT.

This issue is devoted to the topic of "Manpower." Several articles have been written by ASIM committee chairmen and officers, and by ACP President, James W. Haviland, MD, to present a well rounded summary of the issue and of its possible solutions. Dr. Palmer's article, "*Triple T, Options-Manpower and the Internist*" can be found on page 4. Dr. Haviland's "*Some Corollaries to Health Manpower Problem Solutions*" is on page 7.

ASIM BOARD MEETING

Joseph J. Furlong, MD
Editor

The Board of Trustees of ASIM met in New Orleans, September 24-26 with all members present. In the interval since the annual meeting in Philadelphia the affairs of the Society have been conducted by the Executive Committee which met eight times. Minutes of these meetings were reviewed and approved by the full board.

In a separate meeting, Robert E. Rabens, MD, presented his report on the activities and objectives of ASIM/SEREF, the Society's Foundation for Socio-Economic Research and Education. Present projects include the development of a self administered automated history form practical for the internist's office, advised by Truing F. Kanner, MD, University of Kentucky. The Foundation is also assisting with the development of the data base for the computerized Clinical Decision Support System (CDSS). A full account of ASIM/SEREF is planned for an early issue of *The Internist*. All members are urged to include a tax free contribution to the Foundation when paying their annual dues.

Since only dues-paid members will be counted for the allocation of delegates to the annual meeting, the secretary-treasurers of the few components still doing their own billing will be asked to forward the names of individual members when their dues are remitted to ASIM.

Improved liaison with the various subspecialties organizations of internal medicine is being carried out with the goal of increasing their representation and participation in ASIM's affairs.

A major part of the Board meeting was devoted to the increasingly important subject of peer review, now planned as an organized project with local state and national committees and advisory boards. An official position paper of ASIM was developed and sent to Senator Bennett of Utah, author of an amendment to HR 17550 (the Social Security Amendment of 1970) which provides for a Professional Standards Review Organization. ASIM's recommendations will be included in the official records of the Senate hearing on this bill. The recommendations were also sent to Senator Long, chairman of the Senate Finance Committee conducting hearing on the bill. Charlene C. Baer, MD, was designated an official representative of ASIM in a joint project with Foundations for Medical Care in the State of California and four major insurance companies, to study computerized peer review. The Board approved encouragement and support of Foundations for Health Care. An article on this subject will appear in a future issue of *The Internist*.

Because of the initial success of our group life insurance program, dividends to participating members are expected. Recipients will be urged to make tax free contributions to ASIM/SEREF.

Because of the probability of some form of national health insurance being enacted in the future a preliminary report from the Ad Hoc Committee on National Health Insurance was received and reviewed.

Clyde C. Greene, Jr., MD, was appointed chairman of an Ad Hoc Committee to investigate feasibility and need for a socio-economic journal. Individual members interested in this proposal are urged to write to Dr. Greene at ASIM headquarters.

LEGISLATIVE SPOTLIGHT

THE STATUS OF POLLUTION LEGISLATION

Henry B. Blumberg, MD, *Member*
Government and Legislation Committee

Early in 1970, *Newsweek* made the prediction that the subject of environmental quality would, during the year, surpass the war in Vietnam as the issue to which the most lineage in *The Congressional Register* would be devoted. While predictions of this sort are apt to be hazardous, and while the editors of *Newsweek* may have been inclined to hedge at the time American troops entered Cambodia, the problems of the environment have been the subject of large numbers of congressional speeches and a number of congressional bills.

That the state of the environment is hardly a novel consideration of our government is attested to by the fact that, there have been at least 90 separate federal environmental quality programs, with 26 quasi-governmental units and 14 inter-agency committees sharing in the responsibility for environmental efforts. Their proliferation prompted President Nixon's Council on Executive Organization, headed by Chairman Roy Ash of Litton Industries, to recommend the creation of a new agency to oversee all environmental problems.

The first effort to implement the above recommendation occurred on February 4th, when Senator Scott, the minority leader, introduced a bill recommending the establishment of such an agency. In April, a group of Democrats, headed by Senator Muskie, introduced a similar bill, with the main differences consisting of the character of the sub-departments. On July 9th, President Nixon himself upstaged congressional efforts when he announced the creation of two new independent superagencies. The first of these, tentatively named the Environmental Protection Administration (EPA), is to be responsible for water, air, and solid waste pollution management, along with pesticide control and radiation regulation. The second, to be called the Oceanographic and Atmospheric Administration, is to concern itself with the forecast of pollution problems of the future. Congress, which has a veto power over federal reorganization, must do so within 60 days of their announcement, and has apparently allowed their creation.

In addition to reorganization efforts, a number of congressional bills are specifically directed toward alleviating air pollution. Previous legislation along this line led to the creation of the Clean Air Act, which was last amended in 1965, and three separate senate bills (numbers 3229, 3466, and 3546) were all proposed amendments to it. The smog of Los Angeles and elsewhere has assumed significant proportions for over two decades, and scientific studies during this period have pointed an indicting finger at the exhausts of automobiles.

The Democrats sponsored Bill No. 3229 first in December, 1969, which, in addition to extending authorization for the Clean Air Act, provided for special appropriations for research in fuels and vehicles. The Administration's bill (No. 3466) followed similar lines. Both bills authorized the Secretary of HEW to require compliance testing for control of emissions from new motor vehicles.

Senate bill No. 3546, also introduced by Senator Muskie, reflects public concern over the slowness with which plans for air quality control have been developed under previous legislation by the states. As of January, 1970, only 28 of an anticipated 57 air control regions had been designated as such by Secretary Finch, and standards for only one region had received federal approval. Senator Muskie would require the Secretary to designate immediately all air quality control regions, in order to accelerate the establishment of standards by the regions.

Senate bill No. 3466, the Administration's bill, departs from the concept of regional control and standards, and would authorize the Secretary to set ambient air quality standards for the nation as a whole, with respect to any pollutant or combination of pollutants considered dangerous to the public welfare. The AMA appears likely to support the Administration and advocate federal standards in the interest of providing a high degree of uniformity.

FUTURE ROLE OF THE PHYSICIAN'S ASSISTANT

Frank A. Riddick, Jr., MD
Trustee, ASIM
Chairman, Allied Health Professionals Committee

[illegible]

(Continued on page 7)

Generic Penicillin VK

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PAST PROBLEMS AND THEIR SOLUTIONS

MAXWELL G. BERRY, MD
Member, George Weaver Club
President, ASIM, 1963-64

I am sure every president of ASIM has felt that during his tenure events and the organization moved more rapidly than at any other time. This was certainly my feeling. During my presidency, four events took place which have proven of great importance to the direction taken by ASIM since that time.

First, because of the difficulty experienced in internal communications within ASIM (due to its basic composition of independent components), the Board of Trustees decided that the component societies could be better served by the central organization if they were grouped in such a way as to permit each trustee to be assigned responsibility for internal communication for the components within his area. This resulted in a much more effective relationship between the component societies and the national one. It made it possible for components to have an advocate and a consultant within their region.

The second important "happening" during my presidency was the decision, made by the Board of Trustees after much soul searching, to publish an official nomenclature and coding of internists' services. We had gone about as far as we could with nomenclature and coding. We knew full well that the terminology and the completeness of these descriptions were not as perfect as we would have hoped, but there was some urgency to take action. Two things made this urgent: It was a fact that the majority of internists who were members of ASIM had never been able to uniformly define their work, and it was vitally important for our members to have the benefit of what the organization could define honestly and describe up to that time.

Moreover, the American Medical Association was itself trying to develop an official coding and nomenclature for non-surgical services. Under the leadership of James Feller as chairman of the Committee on Medical Services the list was published and, with proper guidance through the House of Delegates, was accepted by the American Medical Association as its official terminology for non-surgical services. This was a major milestone in the internists' re-thinking about his services to patients and about the areas which he could define where he contributed to overall medical care.

Third, relationships with the American College of Physicians were also stabilized during my presidency. Up to this time the American College of Physicians had sent a liaison committee to the American Society of Internal Medicine Board of Trustees meetings. The American Society of Internal Medicine was at the same time in the position of having its official functions monitored by the American College of Physicians and in the unfavorable situation of not having any similar liaison with the policymaking body of the American College of Physicians. It should have been rather easy to foresee that this would have led to a definite misunderstanding. This misunderstanding was unfortunate, but at the same time, it resulted in the achievement of a much more realistic assessment by both organizations of their mutual roles and it ultimately led to a two-way liaison committee at the policy-making level. This has gradually made it possible for both groups to have a mutual understanding of the others' role in the specialty. This relationship has been such that the two organizations—and I say this with much gratitude—have recently been able to work together without a great degree of conflict. It is my earnest hope that in the future they will work more closely together and perhaps develop some type of unified effort.

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FUTURE ROLE OF THE PHYSICIAN'S ASSISTANT

(Continued from page 2)

availability of professionals in deciding whether to expand a five physician section to six physicians, or to five physicians and one or two physician's assistants.

What of the solo practitioner, the two and three man partnership? Since annual salaries for the assistants will probably be in the $14,000-$18,000 range, small practices will probably tend not to secure physician's assistants unless they are in remote areas, have an uncomfortably large practice load, or are willing to pay the increased overhead in hopes of obtaining increased leisure and study time. The practice which needs but cannot obtain an additional physician is the one most likely to secure a physician's assistant. It should be noted that the physician working with an assistant will have an increased number of patient contacts and/or fewer weekly hours of patient contact, but will be carrying an increased ultimate responsibility for patients.

Even though the average physician will not be working with a physician's assistant, the fallout will be considerable in that the physician's assistant programs will serve as examples of which elements of the physician's practice can be entrusted to allied health workers. There will be an increase in delegation of clinical duties to the medical assistant and a demand for the clinically trained medical assistant. The registered nurse will play more of a clinical role in medical practices, and there will be an increase in nurse-clinician programs at both student and graduate levels.

THE TRIPLE T OPTIONS

MANPOWER AND THE INTERNIST

Joseph T. Painter
President, ASIM

That there is a shortage of physician services in relation to the public demand for medical care is well accepted. Whether this lack is due to an actual numerical shortage of services or to geographic as well as specialty maldistribution is debated. The fact remains, however, that there is an inadequate supply of primary medical services, the answer to which must be found if rising patient expectations are to be met.

Many solutions have been proposed, perhaps best capsulized by the "Triple T" approach: Training, Transportation, and Triage.

TRAINING

Medical student and also doctoral curricula must be shortened but more relative to the delivery of medical care and include exposure to all settings where care is provided: home, office, hospital, etc. All allied health professionals must be retrained to expanded role under physician supervision. Prospective training courses for current and future categories of allied health professionals must be task oriented with appropriate integration of requirements to permit lateral and upward mobility as training and experience accommodate.

TRANSPORTATION

A system for rapid transportation of the patient to the location where medical services can be obtained must be developed (from rural to urban area, etc.)

TRIAGE

Some screening mechanisms must be built into the delivery system to identify the levels and intensity of the medical service required.

How do these solutions to the manpower problems affect the prac-

(Continued on page 5)

MANPOWER IN

Maurice Gershenson

Much important data has been obtained from the recently completed survey on Allied Health Personnel in Internist's offices. The survey was conducted under the direction of Frank A. Riddick, Jr., M.D., ASIM Trustee, Addie C. Costello, M.D., Chairman, Practice Management Committee, John B. Bryan, M.D., Chairman, Surveys Committee, and Maurice Gershenson, Statistical Consultant to ASIM. A brief summary of some of the findings follows.

More than 22,000 full-time and part-time allied health workers are employed by these ASIM members who are primarily engaged in patient care. On the average, every internist is assisted by a little over 2 allied health employees. This was disclosed in the recent study of allied health personnel in internists' offices.*

Next to secretary-receptionist (28% of the total number of allied health workers), the medical assistant (17%) is the most frequently encountered health worker followed closely by the R.N., the medical secretary, and the laboratory technician, each accounting for approximately 15%.

Less than 5% are licensed practical nurses and only 1% were reported as physician's assistants. Among the 12% listed as "other," the largest number are in business office occupations and the next largest group are in technical fields, with the majority being X-ray technologists.

Table 1. Distribution of Allied Health Workers By Classification and Region.

Classification	United States	Northeast	North Central	South	West
		(Per cent of total workers)			
Physician's Assistant	1.2	2.3	.6	1.0	1.4
Registered Nurse	15.0	12.8	14.8	14.6	17.2
Licensed Practical Nurse	4.8	2.4	4.7	6.3	4.6
Medical Assistant	17.2	22.3	15.7	16.0	16.9
Laboratory Technician	14.7	11.9	14.6	15.7	15.4
Medical Secretary	14.8	21.9	12.0	15.6	12.4
Secretary or Receptionist	20.5	21.2	20.1	19.8	21.2
Other	11.8	5.1	17.5	11.0	10.8
Total	100.0	100.0	100.0	100.0	100.0

Detail may not add to total because of rounding.

There are significant regional differences both in the number and types of allied health workers employed. For instance, medical assistants and medical secretaries are found in much larger proportion in the Northeast region than in any other.

Nearly 40% of all internist's offices in the U.S. employ an R.N. but the ratio varies from 26% in the Northeast to 46% in the North Central region. Approximately 16% of all offices, on the average, hire a licensed practical nurse but the range is from 7% in the Northeast to 22% in the South.

Table 2. Per Cent of Offices Employing One or More of Specified Classifications of Allied Health Workers, By Region.

Classification	United States	Northeast	North Central	South	West
			(Per Cent)		
Physician's Assistant	3.4	3.7	2.6	3.5	3.5
Registered Nurse	38.9	26.4	46.2	41.3	44.0
Licensed Practical Nurse	15.9	6.8	20.0	22.3	15.5
Medical Assistant	48.0	42.9	46.8	50.3	52.7
Laboratory Technician	44.1	26.8	50.6	53.0	48.2
Medical Secretary	47.7	46.4	45.2	53.0	45.9
Secretary or Receptionist	60.0	43.9	65.7	66.2	66.6
Other	25.6	14.8	26.8	30.3	32.0

INTERNISTS' OFFICES

Statistical Consultant to ASIM

Two-thirds of the offices in all regions hire secretary-receptionists except in the Northeast where only 44% employ this type of allied health worker. In only a small proportion (27%) of the offices in the Northeast is there a lab technician, reflecting in part, the fact that this region has a much larger-than-average number of solo practitioners.

Approximately 48% of all offices hire medical secretaries and there is no great regional variation from this average.

The overall number of allied health workers is lowest in the Northeast, 1.79 workers per internist, and highest in the South, 2.40 per internist. There is an inverse relationship between the average number of health professions employed and the physician-to-population ratio in the regions. The larger the number of physicians in relation to population, the smaller the number of allied health workers in relation to internists.

Region	Non-federal physicians in patient care per 100,000 population (1967)	Average allied health workers* per internist (1970)
Northeast	162	1.79
West	140	2.26
North Central	112	2.38
South	100	2.40
United States	125	2.22

*Full-time equivalents

Although the number of allied health workers serving each internist does not vary a great deal by size of office, there are significant differences in types of personnel. Registered nurses are found in only 28% of one-man offices, 43% of offices with two internists and, 58% of practices with three internists; 83% of all offices with 5 to 9 internists employ a registered nurse and nearly all offices with 10 or more internists have R.N.'s.

Table 3. Per Cent of Offices Employing One or More of Specified Types of Allied Health Workers, By Number of Internists.

Classification	Number of internists in office						
	1	2	3	4	5	6-9	10-19
	(Per cent of offices)						
No. allied health workers	1.6	—	—	—	—	—	—
Physician's Assistant	3.0	1.6	2.7	9.1	5.6	2.1	4.8
Registered Nurse	27.7	43.8	57.4	64.9	83.3	83.3	90.5
Licensed Practical Nurse	9.6	21.3	29.8	37.3	39.1	37.5	52.4
Medical Assistant	44.5	54.7	50.5	50.6	50.6	56.3	61.9
Laboratory Technician	29.8	51.2	70.2	85.7	88.9	89.6	95.2
Medical Secretary	37.3	55.9	63.5	77.9	83.3	87.5	81.0
Secretary/Receptionist	48.7	68.0	80.9	88.3	83.3	93.8	95.2
Other	14.0	32.0	43.6	66.2	58.3	66.7	81.0

The internist in solo practice is likely to employ a secretary-receptionist (49% of offices), and a medical assistant (45%); but few one-man offices have a laboratory technician (30%) or a licensed practical nurse. With increasing office size there is a rapid increase in the frequency with which laboratory technicians as well as other health workers are employed.

Less than one-tenth of the solo practices hire licensed practical nurses, but more than half of the offices with 10 to 19 internists have them.

The smallest variation is in the percentage of offices hiring medical assistants. For this classification the range is from 45 percent of the one-man offices to 62 percent in the largest clinics. For all regions combined the average is 48 percent.

*The data collected covered a sample of 1415 internists in 1000 offices employing more than 4000 full-time and part-time allied health workers (equivalent to 7000 full-time workers).

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ticing internist? What can he do to aid in the immediate solution of the shortage of physician services?

He can exercise the "Triple T" options immediately available to him:

He can *train* his clerical and allied health professionals to perform many traditional but not customarily delegated tasks;

He can transport his patients to the service setting most appropriate to bring efficient, effective care for the medical needs;

He can begin his own system of triage through delegation of greater responsibility to his allied health professionals to more effectively screen patient demands, so that he will have time to apply his knowledge and skills where services are most urgently needed. KWD

PAST PROBLEMS . . .

(Continued from page 3)

The fourth feature of my presidency was the feeling that I had that we, in the American Society of Internal Medicine, had more or less come to the point where we had developed reasonable sophistication in the economics of the practice of internal medicine. With the increased emphasis on the social obligations of medicine, it had become necessary to be more deeply involved in the broad field of "Medical Sociology," as we might call it. All other medical organizations felt this need too, but in 1963 the American Society of Internal Medicine was by far and away the one with the most sophisticated understanding of the socio-economics of medicine.

This early experience in medical sociology made it possible for internists to help in the education of other segments of the profession in this rapidly developing field. This has probably been ASIM's most important contribution as an organization.

THE HEALTH MANPOWER PROBLEM

James A. Collins, MD
Chairman,
Health Manpower Committee

For several years ASIM has been involved in discussions relative to the health manpower shortages — a part of the health care crisis. This involvement is a result of ASIM's concern with serving the public adequately, continuing to provide a quality medical service for patients and, of course, with the plight of the internist in delivering medical care.

At the ASIM Regional Meeting in 1969, Past President Feller questioned whether there is a shortage of physicians or really a shortage of physician's services. There is indeed a shortage of physicians as all knowledgeable authorities tell us. But certainly it could be alleviated through improvement of the utilization of allied health professionals services.

The number one objective: providing more physicians, falls on the shoulders of our medical schools, and they are heeding the call. Approximately 3,000 more students will be enrolled in U.S. medical schools this year. However, many of our schools are in financial stress and need monetary help from our legislators to allot revenues for school operations to permit them to increase their enrollment. This help is still years away from actual solution of the problem.

Help is needed now. ASIM has initiated a three-pronged attack, conducted by three committees concerned with various aspects of the health manpower problem.

1. The Ad Hoc Committee on Allied Health Professionals under the Chairmanship of ASIM Trustee, Frank A. Riddick, Jr., MD.

2. The Health Manpower Committee under the Chairmanship of the writer.

3. The Professional Interrelationships Committee under the Chairmanship of Charles R. Beeson, MD.

Dr. Riddick's committee is primarily concerned with new allied health professionals and their relationship to the internist. Currently this committee is most involved with the newest member of the

health team: the physician's assistant. Under ASIM leadership, top echelon members of organized medicine, including the AMA, met in Chicago to discuss this problem on two separate occasions. As a result, the Ad Hoc Committee on Allied Health Professionals is attempting to draft a task analysis of what this allied professional can, will, and should do in the delivery of health care. When this is completed, the American Association of Medical Colleges will be able to map-out the educational needs to satisfy these task requirements. Dr. Riddick and his committee are steering this project so that this new person can enter the health care system in all of our states at an early date. The AMA is cooperating in this endeavor together with the American College of Physicians, the American Association of Medical Colleges, and the American Association of General Practice.

The Committee on Health Manpower is studying and evaluating areas in the health care system where existing allied health professionals can be used more effectively. The Health Manpower Committee assignment has been greatly assisted by the results of the recent survey on the use of allied health professionals in internists' offices conducted by ASIM's Surveys Committee, chaired by John Bryan, MD. A preliminary review of the survey indicates that there are many allied health professionals who are not being used to their greatest potential. ASIM members indicated they feel that appropriately trained and supervised personnel could carry out duties which are not currently being delegated, such as recording parts of the general history, taking blood pressures, and taking certain measurements. The survey also indicated that many internists use registered nurses to perform tasks that could easily be assigned to personnel with less training. Internists should take a hard look at the tasks of their office assistants. There are many areas in which the allied health professionals can help conserve the physician's time, making him and his office more efficient, and thus providing more medical services.

The Professional Interrelationships Committee has several assignments, among which is the study of the relationship between the internist and the allied health professional he employs. To exchange information and to explore common avenues of action, this Committee met jointly with the Committee on Health Manpower in Chicago in September. Among the recommendations resulting from this meeting which will be reviewed by ASIM's Board of Trustees in January are the following:

1. That ASIM support the amendment of medical practice acts so that legal barriers to an increase in delegation of tasks to allied health personnel by physicians might be removed.

2. That ASIM recommend a national goal of 20,000 new graduate physicians per year be established (twice the present output).

3. That the total period of training for the awarding of the MD degree be shortened to a total of six years of college and medical school.

4. That such legal impediments as a required four years of medical school training for state licensure be removed.

5. That governmental support be given to medical schools so as to create an incentive for increasing the number of candidates accepted and trained. A per capita subsidy is one means to this end.

6. That ASIM offer its services nationally and through its component societies to advise medical residents on

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SOME COROLLARIES TO HEALTH MANPOWER PROBLEM SOLUTIONS

JAMES W. HAVILAND, MD
President, ACP

In keeping with today's great efforts to get physicians trained and out in the workaday world, a number of ways of solving the "health manpower shortage" are being tried. Among these are: 1) Shortening the preliminary or pre-medical education; 2) shortening the medical education itself; 3) encouraging earlier selection of a field of concentration or specialization; 4) ABIM offering its written examination for certification after two years of training in the broad field of internal medicine. Simple mathematical calculations show that for the "kid who is good with the books and exams," it is now possible, theoretically, to obtain an MD degree five years after completion of high school, and to have passed ABIM's qualifying exam and to receive a Certificate of Qualification in general internal medicine after seven years of education and training following graduation from high school.

Such headlong progression of a hitherto steep and rather long path raises some questions for all of us. Aside from taking steps to assure that internists will not be divided into two mutually exclusive groups (the generalists, with their "quickie" degree and certificate, and the sub- or super-specialists, with their prolonged and, at times, somewhat esoteric preoccupation with rather limited fields), we must face several problems, the responsibility for solving which will devolve directly on us from this speed-up in education and training: 1) Recruitment, 2) continuing education and peer review, and 3) maintaining and nurturing the quality of effort, the *esprit* which has characterized internists as the prototype for all physicians.

By way of explanation, recruitment may well become much more difficult as the "captain of the team" becomes farther and farther removed from the actual delivery of care — the actual working with patients. After all, most of us gain the recompense necessary to keep us at those long hours through the satisfaction which goes with helping those in distress. Furthermore, medicine's competitive position among the other higher educational options has certainly suffered as a result of the stance of derogation assumed these past twenty years by politicians, planners, and those who espoused early the cause of nationalization of health care delivery, aided and abetted by the mass media scribes. What we, as a profession, can do to remedy this is not at all clear, save to persevere, and to hope that right will win out in the end.

As far as continuing education and peer review are concerned, it is going to be much more important in the future to have available a wide variety of options through which the internist can keep up with scientific advances. First of all, his initial education will have been considerably more abbreviated than is presently the case. This means that not only will he have to get additional supplements of hard facts, but also that he will have to have the opportunity to try them periodically out by actual application in an institutional educational setting. Under such circumstances, I am sure that peer review will become much more understandable, useful, and desirable. Just how this will be timed to fit

into recertification and re-licensure has not yet been worked out.

Finally, with regard to the maintenance and nurturing of the quality of effort—our *esprit*—I have in mind "that little something extra" which has seemed to set dedicated physicians apart from the other professions. After all, doctors are just ordinary, well-educated citizens, who have come up through "the system" and have achieved an almost guild-like adherence to the goal of quality. A little appreciated divident which has accrued to society from our long educational and maturation process is this *esprit*, which seems to have rubbed off on us, or to have been absorbed by us as we worked and learned side by side with our mentors and peers. One of the great challenges which faces us as physicians and as internists is how to cherish and pass on "that little something extra" as we face the future with all its demands for more services, for more efficiency, and for more economy.

THE HEALTH MANPOWER PROBLEM *(Continued from page 6)*

available practice locations and areas of special need, and that the availability of this resource be made known to department chairmen of resident training programs.

The Committee also discussed the need for an educational program directed 1) toward the physician to teach him acceptable ways in which he might use his assistants more extensively, and 2) toward the public to teach them to accept services appropriately rendered by assistants under supervision.

ASIM's expertise is being sought by other organizations concerned with the health manpower issues. It has been asked to provide representation at meetings concerned with manpower problems by AMA, HEW, and the American Association of Medical Assistants (AAMA). This latter organization has been instrumental in stimulating a discussion toward the educational needs of the Medical Office Assistant, and to this end a "Program Coordinating Task Force" has been appointed by the AMA to plan, discuss, and map-out the educational needs for the medical assistant. This writer was the ASIM representative at that meeting in September, 1970.

The American Society of Internal Medicine is involved in the pressing problem of health manpower and is providing leadership and direction toward its solution.

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ESTIMATES

Projecting from the results of the survey, it is estimated that approximately 21,000 full-time allied health workers serve members of ASIM engaged primarily in patient care. They are distributed among the various types as follows:

Classification	ASIM Members
Physician's Assistant	*
Registered Nurse	3,200
Licensed Practical Nurse	1,000
Medical Assistant	3,600
Laboratory Technician	3,100
Medical-Secretary	3,100
Secretary-Receptionist	4,300
Other	2,500

*No estimate is given here for the number of physician's assistants because it is believed that respondents to the survey may have not understood the definition of this classification.

The foregoing estimates are in terms of full-time equivalent workers. Counting the number of different individuals, both part-time and full-time, separately, would raise the total about 7½ percent to 22,600.

The recent survey not only determined the number and types of allied health personnel employed by internists but also the tasks these workers now perform as well as the attitudes of internists about which of their functions could and should be delegated. The information on delegation of tasks has been summarized and will be released shortly. END

Professional Opportunities

INTERNIST — Board-Certified or Eligible to join six-man multispecialty corporate group. Salary open, corporate fringe benefits available immediately. Stock purchase plan optional after eighteen months employment. Located thirty miles north of Boston near ocean, lakes, and mountains. Reply in full including salary requirements and curriculum vitae to Kirwan T. McMillan, MD, 116 Summer St., Haverhill, Mass. 01830.

Fifty man group in Texas Medical Center (Houston) needs Board Certified or eligible Internists with specialties in Allergy, Cardiology, Nuclear Medicine, Pulmonary Diseases and Endocrinology. Also Board qualified Internists or Occupational Health physicians to develop and direct aviation medicine and executive health programs. Teaching and research opportunities in adjacent medical center. Eligible for partnership after two years. Excellent fringe benefits and retirement program. Send curriculum vitae with first letter to Carlos F. Taboada, M.D., 6624 Fannin, Houston, Texas 77025.

Multi-specialty clinic presently with five internists desires INTERNIST. Excellent opportunity. Third largest trade area in Oklahoma. Contact: F. J. Martin, M.D., 100 East 13th, Ada, Oklahoma. 405-332-5353.

INTERNIST — Wanted as an associate for practice in San Jose, California. Ralph O. Hayden, M.D., 2074 Forest Avenue, San Jose, California 95128, Tel: (408) 294-7425.

LETTER TO THE EDITOR

Living in an "emerging" country with all the attendant problems of its medical care programs makes me more keenly aware of the great value of the activities of ASIM. (In much of Europe also there is little recognition of Internal Medicine as a specialty.)

We are active in peer review mainly as an educational-audit method but since better quality in the long run means more costs, this aspect of cost also becomes important to an organization with 65 physicians and expenditures of $13 million per year.

The internists in our group are the most active in maintaining and improving quality.

If the Committee on Quality Evaluation of ASIM has more information on ways of measuring and assessing quality, I would like to obtain it, even if still in the research area.

Both hospital (in-patient) and out-patient care needs assessing and more study and practical trials in the case of out-patient care is needed. With 450,000 out-patient visits per year in our clinics and a considerable interest in quality and cost, we have gained some experience but need any information available on ways of measuring and improving quality in an out-patient setting.

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Editor's note: Evidently the problems of internal medicine in this field are international. ASIM's Committee on Quality Evaluation has responded to Dr. Perrine's request for information.

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