DEPARTMENT OF THE AIR FORCE
SCHOOL OF HEALTH CARE SCIENCES, USAF, (ATC)
SHEPPARD AIR FORCE BASE, TEXAS 76311

REPLY TO ATTN OF: MSDM

31 October 1972

SUBJECT: Physician Assistant Conference, April 1973

TO: CCM

ACTIONS ACCOMPLISHED

1. Approval requested and received from Hq ATC and Hq USAF to host the conference (Sep 72).

2. Material and information requested and received on the 1972 conference conducted at Duke University. This included cost data, programs, and a list of attendees. (Aug 72).

3. Formal notification of the conference submitted to the Wichita Falls Board of Commerce and Industry, and the required "Bid" Form completed. (30 Oct 72).

4. Contacts made with the Office of the Surgeon General, USAF, the AMA, The Board of Commerce and Industry (BCI) and with the Office of the Secretary of Defense, relative to the needed "Seed Money" ($1,000) for printing and publicity. (Oct 72).

5. A meeting was conducted with Tom Godkins, President of the American Academy of Physicians' Associates, and Bill Stanhope, Director of the Physician Assistant Program, University of Oklahoma, on 20 Oct 72 to discuss an agenda for the conference as well as finances.

6. Discussions were held with Mr. Ralph Kuhli, Director of the Department of Allied Medical Professions and Services, AMA, relative to possible assistance from the AMA in obtaining a mailing list and a possible loan or grant through NIH. (18 Oct 72).

7. Meeting with Colonel Connie Sparks (Retired) of the BCI to discuss lodging, food, transportation, printing, and finances. BCI has agreed to act as fund receiving and disbursement agent for the conference. (30 Oct 72).

8. Letters dispatched to 204 attendees of last years conference announcing the meeting will be held at Sheppard AFB in April 1973 and requesting recommendations for format, speakers, and papers. (23 Oct 72).

9. The following tentative agenda, with 5 major categories to be addressed at the conference, has been developed:

a. Welcome Address

b. Keynote Speaker

c. Panels and Subject Matter:

(1) Definition and Utilization

(2) Education

(3) Certification

(4) Health Teams

(5) Legal

d. Banquet with Speaker

10. The following rooms in the SHCS have been identified for use for the conference:

a. Room 201 - Auditorium for plenary sessions, keynote address, and welcome.

b. Room 204 - Exhibit Area

c. Room 1015 - Convention Headquarters and Registration

d. Rooms 2082, 2083, 2085, and 2087 - Meetings and Panels.

MEETINGS SCHEDULED AT THIS TIME

1. Meeting with Mr. Godkins and Mr. Stanhope at the University of Oklahoma, during the week of 1 Nov 72. Primary subjects will be to obtain their mailing lists, discuss recommended speakers, and assistance that can be given by their office in the conduct of the conference.

2. Meeting with the Academy of Physicians' Associates and the American Registry of Physicians' Associates to be conducted in Washington DC on 10 Nov 72. Primary subjects for discussion will include finalization of conference dates ($2\frac{1}{2}$ or 3 day duration), agenda, speakers, panels, and finances. An appeal will be made at that time for 10 to 15 personnel within these associations to pre-pay their registration fees now, to resolve the problem of required "seed" money.

PLANNING AND COORDINATION TO BE ACCOMPLISHED (Action Dates Indicated)

1. Finalize meeting dates - 11 thru 13 April recommended. (10 Nov 72).

2. Coordination with local motels for information on room availability, cost of rooms, courtesy transportation, availability of suites suitable for use as hospitality rooms for exhibitiors, caucus rooms and lounges.(13-17 Nov 72).

3. Coordination with the Country Club and the Officers Club for Banquet and Coctail Receptions. (Initial Contacts 16 Nov 72).

4. Coordination with Base Commander on use of Air Force buses for transportation. (Initial contacts 14 Nov 72).

5. Coordination with Security Police to clear the attendees who plan to drive to the conference. Establish parking area for same. (14 Nov 72).

6. Coordination with wives group of the SHCS to plan activities for wives who accompany attendees. (Jan 73).

7. Establish bank account with BCI (ASAP after initial money received).

8. Coordination with Major Smith (MSDM) to assure no conflict with Basic Officer Orientation Courses. (1 Nov 72).

9. Identify rooms within SHCS suitable for lounges and caucus type meetings. (2 Nov 72).

10. Printing of announcements, notification of official agencies (AMA, etc), invitations, and pre-registration forms. (ASAP after 10 Nov 72 Washington meeting, but not later than 15 Dec 72).

11. Finalization of guest speakers and contacts for same. (ASAP after 10 Nov 72 meeting in Washington).

12. Determination of honorariums and fees to be paid guest speakers. (As soon as practicable).

13. Coordination with protocol for VIP room reservations (14 Nov 72).

14. Appointment of a committee to assist the Project Officer for the conference. (15 Nov 72).

15. Develope and print conference programs. (Immediately upon receipt of final speaker acceptances).

16. Coordinate catering of coffee and donuts for break periods. (Dec 72).

17. Establish and coordinate car pool (staff cars, cars of volunteer SHCS personnel) for use to transport VIP's and to provide required special transportation needs for conference attendees. (Feb-Mar 73).

18. Coordination with office of the Judge Advocate as required.

19. Appointment of "Hosts" for prominent VIP's as necessary and in accordance with protocol.

20. Contacts with Secretary of Defense, Secretary of HEW, Director of the VA, President Elect of the AMA, and President of the AAMC to request their participation as panel members to discuss definition and utilization of the Physician Assistant. (ASAP after election fallout).

Nicholas C. Nicholas
NICHOLAS C. NICHOLAS, Colonel, USAF, BSC
Conference Coordinator

PROPOSED AGENDA Monday 9-13, 1972

for

FIFTH ANNUAL CONGRESS

A. Keynote Session - The Health Profession
Edmund Pellegrino

Workshops (x 4-5)

ANA
NLN
ASAHP
Consumer Advocate
Others

320

B. The Physician's Assistant

1. Definition/Education
2. Evaluation/Certification
3. Utilization
4. Legal/Socioeconomic Aspects

Expansion of (B) above -

1. Definition/Education

a. AMA - Malcolm Todd, M.D.
b. AAMC
c. Association of Teaching Hospitals
d. Association of Physician's Assistant Programs
e. Questions/Topics for Workshops

(1) "How to do it" sessions for programs in the planning stages
(2) Standardization of curriculum content
(3) Core curriculum, systems analysis for the (Navy) PA as he interfaces with other health professionals.

2. Evaluation/Certification

a. NBME
b. AMA
c. DHEW
d. FSBME

e. Workshops

(1) What is presently being done and what can be anticipated in evaluation/certification?
(2) Will the National Board of Medical Examiners' qualifying examination give the PA adequate credentials which would "stand up in the face of other not-so-friendly" health occupations?
(3) How will equivalency be established for this new health profession?
(4) Will evaluation speak to quality of medical care? Cost effectiveness?

3. Utilization

a. VA
b. DOD
c. DHEW
d. AHA
e. Workshops

(1) Analysis of actual use of PAs in private practice
(2) Public education: discussion for hospital administrators who might be using PAs but who do not operate specific PA training programs. How shall the consumer get to know the PA?
(3) Utilization in varied settings: institutional, private practice, large urban communities, rural areas, as specialist-assistants.

4. Legal/Socioeconomic Aspects

a. Persons to invite to speak:

(1) Hershey
(2) Curran
(3) Willig

b. Workshops

(1) Socioeconomic impact
(2) Licensure
(3) Reimbursement by 3rd party payors
(4) Prescriptions/dispensing of controlled substances.

19 CLOSING THE PROFESSION GAP—SOME NOTES ON UNITY OF PURPOSE IN THE HEALTH PROFESSIONS

EDMUND D. PELLEGRINO

This is a book of hope and innovation, a tribute to the vigor of the youngest and newest health professions. It is shot through with enormous promise for a better congruence than now exists between public expectations and actuality in health care delivery.

What is most seriously missing is the glue that will forestall the natural centrifugal tendencies already driving these new professions toward independence, autonomy, and disparate educational and service modes. The historical reasons for these centrifugal urges are not to be denied, but a latticework of new relationships must be constructed to give form and comprehension to the entire effort. Otherwise, the birth of so many new professions can only lead to frustrating Brownian movements instead of synergistic and purposeful motion toward a clearly defined mission: optimal participation of all our people in whatever benefits medicine, science, technology, and humanity can bring to the betterment of human existence.

The only real obstacle lies in the realm of human relationships and the peculiarly vexed arena of relationships lying between the professions—some ancient, honored, and confident, and others young, eager, and sometimes unmindful of what history can teach.

This "profession gap" cannot be allowed to widen. Even as the allied health professions gain strength, conscious efforts must be made to bring them and the established professions into a new professional structure with a clear mission and a unification of purposes—a health profession, rather than health professions. These closing comments are devoted to some first steps in closing the gap.

Modern society has imposed a clear and specific mandate upon all its health professions: They are the instruments through which health is to become a civil right of all citizens and an indispensable element in the improvement of human existence. This mandate derives from an increasingly acute public perception of the capabilities of medical science and technology. It is also the criterion upon which public support and acceptance of the health care establishment will be based.

We are unique in history in possessing an unprecedented span of capabilities in medicine. But we are equally impressive in our failure in the realm of human and social engineering to find how to enable each health profession to make its optimal contribution to some integrated system ordained specifically for the welfare of patients and society. Without the removal of this impediment, it will be impossible

Editors' note: In an era of changing relationships among the several health professions, the voice of Dr. Pellegrino has been accorded respectful attention from proponents of all points of view in the health manpower arena. He has been an effective proponent of relationships based on mutual respect, and, as Chairman of the American Medical Association's Advisory Committee on Education for the Allied Health Professions and Services, Council on Medical Technology, has sought to maintain cooperative and constructive relationships between AMA and the representatives of the allied health professions.

At the present stage of evolution, it is regrettable that no one voice can yet speak for the allied health professions; however, the editors are proud to present here a progressive viewpoint on the subject of unity of purpose in the health professions, as conceived by this outstanding spokesman of the medical profession.

either to fulfill the social mandate or to actualize the technical capabilities society has a right to expect.

The prickly underbrush that obstructs the way is rooted in the sticky soil of professional prerogatives, proudly held traditions, and ethical and legal constraints. The lay observer is confused and sometimes scandalized by current controversies about accreditation, licensure, certification, and role definitions. Having hailed the recent birth of the new health-related professions as a boon to health for more people, the public sees only the obfuscation of its needs in battles over their paternity and their place in the hierarchy of professional functions.

The public will not long tolerate such unseemly debates among professionals. It is already taking actions, some of which are ill-advised and precipitate. Legislators in many states are moving rapidly toward recognizing new professions by licensure or registration and redefining the scope of established professions. Educational programs of uncertain quality and utility are receiving public support at junior and four-year colleges. The irregular and less creditable healers and practitioners are given increasing credibility and recognition. In short, the public will is being expressed out of desperation to satisfy unmet needs. The vacuum created by lack of a concerted effort by the health professions themselves will assuredly be filled. The clear and present danger consists of the establishment of a parallel system of health care that may well threaten the quality, safety, and competence of the care our people receive.

Only one rational and effective measure can obviate these deleterious tendencies—nothing less is required than a cooperative and mutual effort among the health professions themselves to assess the task each can perform for the patient, the levels of education required for each group of tasks, and the conditions of practice that will maximize safety, competence, and efficiency. Even as enrollments in schools of health related professions are enlarged, there must be an energetic effort to inquire whether we are making full use of all the potentialities of already trained health professionals. The optimal deployment of this existing manpower is, for immediate purposes, even more relevant than the open-ended expansion of new educational programs or the undirected proliferation of new professions.

The problem will not be resolved by a massive study, commission report, or governmental decree. Rather, all the health professions must voluntarily engage in a new relationship with each other and on a continuing basis. What is required is tantamount to a genuine interprofessional effort of ecumenic dimensions. The eventual outcome, if the effort is really to be successful, will be the emergence of a unified health profession, rather than a disparate series of competing professions. The subdivisions of this new entity will be built around the needs of patients and communities and not the boundary lines of status, prerogative, or self-assumed superiority. Levels of function and education will be determined by patient care needs; fewer subdivisions will exist than now, and the whole will be more functionally organized. A common ethic and open access through educational mobility at all levels will strengthen the interrelationships of all practicing health professionals.

We are, of course, very far from any such idealized amalgamation of the health professions. Indeed, the predominating tendencies appear to be all in the opposite direction—toward separatist definitions of functions, ethics, accreditation, and education. Serious practical and ideologic obstacles bar the way to unification of the health professions, or at least to more productive interprofessional relationships. However, without a reversal of the current practices, there is little chance for optimal utilization of existing health manpower. The result will be further duplication of functions and frustration of public expectation that more manpower will mean more service.

A prime source of the current divisive tendencies resides in the methods by which

the health professions customarily set about defining tasks, roles, and functions. Two major modes of definition are in vogue now. These are the methods of definition by delegation and by self-arrogation.

Definition by delegation consists of deciding what tasks are purely technical in nature, repetitive, programmable or burdensome, time-consuming, and unsatisfying. These are assigned to some less extensively educated professional or subprofessional group. To assure safety and competence, the tasks are performed under supervision of the older profession that has established and influences the training program. Definition by delegation may involve referral of a given set of functions to some other existing profession or creation of a new subprofessional or technical level. Nursing has used this technique in defining levels of nursing function at the associate and baccalaureate degree levels; almost every specialty in medicine is proceeding by a similar route in establishing specialized physician assistants, such as the orthopedic physician's assistant and the urologic physician's assistant. Dental medicine has done the same for the dental hygienists and dental technicians. Many of the existing allied health professions, like medical technology and radiologic technology, were generated similarly.

Definition by delegation suffers from some serious defects. It can too easily serve the interests of the parent profession and only secondarily those of the public. The older profession is relieved of burdensome and time-consuming tasks but by a unilateral process carried out in isolation from other health professions with overlapping functions or capabilities. Control of education and practice remains with the older profession. A servile relationship is too easily established, and there is the eventual emergence of dominance by the senior group, with restriction of opportunity for development of the technical professions.

The other major mode of role and task definition is that of self-arrogation. In such cases an existing health profession extends the ambit of its functions into an unoccupied or neglected zone of patient care or, when manpower deficiencies are acute, takes on the functions of another profession. The health professions other than medicine are apt to take this route in the face of growing geographic or functional shortages of physicians. The action is again unilateral and taken without consultation with other professions. The primary purpose is often "upgrading" one profession. Other professions that might perform the same functions are not consulted, and hence no agreed-upon realignment of functions can result. There is too much emphasis on enhancing professional images and achieving "independent" status. In truth, the eager rush to lay claim to some new fraction of the spectrum of patient care needs has some of the undignified features of a land rush.

Both forms of definition are unsatisfactory for today's health manpower needs. They foster duplications of function, proliferation of educational programs and titles, as well as overlapping responsibilities. More seriously, the patient for whom the whole endeavor is presumably designed is often lost in the territorial struggles. He becomes the victim of further fragmentation of services, which become even more expensive and less comprehensible than before. As the numbers and kinds of health professional expand, there results an almost proportionate constriction in personal services to the patient. Last, the newly created assistant, who at first eagerly takes up the new tasks, will soon discover the limited exchangeability of his education and his consequent excessive dependence upon the parent professional. In sum, the net effect of meeting patient care needs by means of delegation or arrogation is inevitably an enervating competitiveness in place of the needed cooperation and coordination.

Even more serious is the inevitable erratic course such inadequate means of necessity encourage. They prevent the development of a rational plan that assesses needs, determines which of the existing

health professions can meet these needs and what levels of education are requisite, and proceeds with this goal in mind to the most efficient deployment of existing and future personnel. Such a plan is only possible with the highest degree of interprofessional cooperation and agreement on goals and means, as well as on changed authority structures. Such agreements must be attained before, rather than after, more personnel are produced. If any plan is to work, it will require that all health professions engage in continued mutual interaction, so that adjustments in the long-range plan demanded by experience can be introduced without delay.

No realistic appraisal of the probabilities of a move toward unification of the health professions for immediate or long-range benefit of the health care delivery system can ignore the central position of the physician in all these efforts.

The physician experiences special problems and responsibilities in any new set of interprofessional relationships. His profession is the longest established, clinically the most authoritative, and publicly the most respected. He is the dominant figure in institutional decision making and in the lay mind. His position is circumvallated with prerogatives, prestige, and technical know-how. Moreover, his economic and legal status are threatened by any drastic change in the scope of his responsibilities.

Despite this, the physician has been undergoing a gradual but profound transformation of his image and his mode of practice in the past century. In response to the expansion of science and technology, he has had to become more a scientist and technologist. More recently, he has had to conform to drastic alterations in the social, economic, and political milieu of his practice. He is being bureaucratically organized, confronted with increasing institutionalization of his practice, and, with it all, experiencing an erosion in general public esteem.

With these challenges as yet incompletely met, the physician now faces perhaps the most serious accommodation of all—the recognition that he must share both his relationship with the patient and his responsibility if a uniformly accessible system of health care is ever to be provided. This will require modification of the centuries-old Hippocratic ideal of the benign but authoritative physician who is both surrogate and advocate for his patient. The physician's role can be defined realistically today only in a nexus of complicated interprofessional relationships wherein his ancient decision-making authority is to varying degrees shared with others. Under the circumstances of modern "team" practice, the physician's authority, even in the care of his own patient, may not always be "primary."

In the face of these not inconsiderable challenges, physicians understandably exhibit antithetic responses. The traditionally minded insist on retention of all established prerogatives. They argue that for the safety of the patient they must at all times retain primacy, final responsibility, and control over the work of the other health professions. The physician, they avow, should define the tasks of the other health professions by delegation and control the education and the practice of those who assist him.

On the other hand, the physician more responsive to the dominant cultural tendencies of the day takes a view more consistent with the ethos of an egalitarian society. He appreciates that physicians, like others in a complex society, must work closely with others who, in the interest of better distribution of health care, may well assume some or many of his functions. He expects also to become a leader, not by fiat or the possession of a specific degree, but by virtue of greater competence in some declared area. This view recognizes that the requirements of society for health services must override even the most firmly established patterns of care.

Such matters as competence, confidentiality, and ethical conduct are no longer solely the private concern of the doctor but

are shared with other members of health team. Physicians who hold this set of values can more readily accept other health professionals as partners who are in reality members of one and the same health profession. Each member of this health profession has specific tasks to perform that are dictated by the changing needs of the patients.

It would be impractical to expect even the well-disposed physician, nurse, pharmacist, or practitioner of the allied health professions to move quickly toward the amalgamation of their professions. A new set of relationships will demand sacrifice of cherished prerogatives difficult to accept, even for so worthy a goal as optimal health care for all. The history of misunderstandings is too immediate, the record of suspicions too fresh, and the economic, legal, and ethical prohibitions too evident right now. If we accept the ultimate creation of a unified profession as a desirable and, indeed, a necessary end point, what immediate steps are possible toward this goal?

The most immediate, fruitful, and crucial point of contact between the professions is the current need to develop responsible alternatives to the present mechanisms of delegation and self-arrogation for determining who shall perform what tasks in patient care. A first and essential step lies in the formation of task forces or practice commissions that will permit mutual and cooperative examination of concrete clinical situations to determine what patients need in those situations and then decide which tasks can be performed by existing health professionals and under what conditions of safety for the patient, as well as economy and efficiency. These task forces must have specific assignments and must eschew global solutions to all the problems of interprofessional relationships. They will otherwise becloud their efforts in tedious ideologic debates over primacy, independent and dependent functions, and vigorous defenses of self-interest.

Beginnings are being made in this direction on a limited scale. Practice commissions involving nursing and medicine have been recommended by the National Commission on Nursing Education and Practice. Another example is the recent meeting of representatives of professional organizations in medicine, nursing, allied health, and hospital administration called by the Department of Health, Education, and Welfare for the purpose of defining specifically the extended role of the nurse in primary, acute, and long-term care. Still another example is the Joint Commission organized under the auspices of the AMA, the National Commission on Accreditation, and the Association of Schools of Allied Health Professions to make recommendations for improvement in accreditation of the allied health professions.

Additional examples in recent years are the following: the several national conferences on relationships of physicians and nurses co-sponsored by the AMA and the ANA; the replication of these conferences in many states; the interagency committee of the American Medical Association, the American Nursing Association, and the National League for Nursing; and the cooperative efforts in accreditation sponsored by the AMA and its Panel of Consultants drawn from fifteen major allied health professional associations under the auspices of the AMA's Council on Medical Education.

These are commendable first efforts; they must be encouraged and extended if the health professions are to meet public expectations for better care more responsibly. We yet lack, however, a national forum or a national body specifically charged with development of a rational plan for definition of the health professions, their tasks in patient care, their interrelationships, modes of education, and conditions of practice. Such a body, representing at a minimum medicine, nursing, pharmacy, dentistry, the major allied health professions, hospital administration, and consumers, needs urgently to be formed. Some of the current efforts described in the previous paragraphs could be subsumed as subcom-

mittees or task forces of the more widely representative national group.

The leadership and the locus for formation of a national health council of this type can come from several possible sources. The professional organizations could come together voluntarily to form this new group, an overarching organization for their purposes. Or they might be organized under governmental aegis as an advisory group to the President. A revised and upgraded health division of the Department of Health, Education, and Welfare could serve this function; the newly formed National Institute on Medicine of the National Academy of Sciences is another possibility. Whatever the aegis, the time is propitious for a continuing, cooperative, and mutually acceptable realignment of tasks among existing health professions, a definition of new professions needed, and a design for educational programs to prepare personnel to practice at the defined levels in a revised health care system. The public demands for universally available and accessible health care for every citizen will eventually force such a mechanism to be created.

While all levels of care must be examined by such a group, perhaps the easiest place to start would be in the realm of primary, emergency, or preventive health care. Provision of such services on a round-the-clock, seven-days-a-week basis is the most common unmet need perceived by most communities in this country, whether they are urban, rural, or suburban. Much of the current demand for more family physicians, physician's assistants, and other health personnel is deeply rooted in the hope that more manpower will eventuate in better availability of these types of care.

Most health professionals would accept primary and emergency care as an unmet need that requires new approaches and new uses of personnel. Starting at this point of common agreement, an interprofessional group can ask some direct questions: What tasks must be performed in primary care? Which existing health professionals can perform them now or with some additional training? Are existing professionals willing to accept these tasks? If not, what new personnel are needed and how should they be educated? Will the reassignment of certain functions lead to better distribution, more efficiency, and greater economy?

It is hard to envision lasting answers to these questions and effective implementation of a design based upon them without the sort of national, interprofessional, cooperative group mechanisms we have suggested. The time has never been more suitable for such a effort. With primary care as the initial point of departure, the discussion can readily move to other types of care.

In these endeavors the physician has a unique opportunity for a new kind of leadership. He must demonstrate his willingness to examine each of his own functions, no matter how complicated. Generally speaking, he will find it easier to delegate technical functions and more difficult to do so with those requiring cognitive or judgmental skills. Working in collaboration with the other health professions, the physician is essential in defining the conditions under which a particular function can safely and ethically be transferred to achieve better distribution of care to more people.

With specific tasks mutually agreed upon and accepted, the health professions can begin to deal with new relationships in that necessary and much vexed instrument, the health care team. Physicians must soon appreciate that the M.D. degree does not confer the capability or the right of instant and perpetual leadership of any and all health care teams. The most useful model of the team will turn out to be what sociologists call a "temporary system"—a group of individuals, each with special talents, united for achievement of a special objective and having existence only until the objective is achieved. The team derives its leadership, composition, function, and duration from the needs of the patient. In this view, the physician is captain of the

team when the major needs are for diagnosis and critically important or sophisticated techniques. When other needs are dominant, as in chronic care and preventive or rehabilitative medicine, other health professionals may quite justifiably assume a primary role for variable periods of time. The success and reliability of the nurse in intensive care and coronary care units and as a pediatric assistant amply demonstrate how another health profession may assume major responsibility for some of the physician's critical functions in patient care.

Medical educators could do much to foster better interprofessional relationships by providing educational experiences in team leadership as part of undergraduate and continuing medical education. Through such team experiences, the physician will learn specifically how to coordinate a group of health professions and also how to be a team member himself when the patient's needs dictate a shift in leadership.

Another essential point of discussion that must engage the professions is the need for a common set of ethical and legal guidelines. Sharing of responsibility within a viable concept of the health care team is complicated and impeded by unresolved ethical and legal questions. The Hippocratic ethic has for centuries stressed the physician's sole responsibility for the welfare of his patient, yet neither the traditional ethics of the medical profession nor existing medical practice acts were designed for the complex institutionalized multiprofessional health care system of today. There is, therefore, a need for a new and expanded ethic that recognizes the intricate web of shared responsibilities essential in today's medical care. In place of a series of separate ethical codes for each profession, there is a need for an ethic of the health professions that will embrace all who serve the needs of patients. Medical practice acts must increasingly take into account the shared responsibility that accompanies the delegation of even some of the physician's functions. Legal and ethical principles are needed that can acknowledge the realities of team care and the varying levels of responsibility therein. Corporate and shared responsibility for negligent acts must be taken into account through a common set of ethical principles that bind all members of the health care team by a common set of duties designed to protect the patient, even though his care is diffused among a number of health professionals.

The high degree of interprofessional cooperation and sharing of responsibilities required in modern health care will dictate greater efforts at interprofessional education. The organization of all health professional schools into university health sciences centers already provides settings for common or shared educational programs. Students need the opportunity to see their own professions in the total context of what patients need and what each profession can do to meet those needs. This is best achieved by experiences as students, working as members of interdisciplinary teams. Such experiences should later make them more comfortable with the idea of shared responsibility and with the ineluctable fact that ultimately the worth of each profession is related to what it can do for a patient and not what title or academic degree it exhibits.

The essential interprofessional activities outlined here, such as task analysis, role assignments, evolution of a common ethic, and shared education, are some of the first mutual responsibilities that a new amalgamation of the health professions must shortly undertake. They will require a truly ecumenic spirit among the several health professions that may eventuate one day in the formation of a single profession —Medicine with a capital "M."

This may be the only real way to harness effectively the potentialities of all those who contribute to patient care and to avoid some of the less edifying features that have so often characterized interprofessional relationships. Difficult attitudinal and behavioral changes will be required of all; status, established privileges, and legalisms

must be eschewed. The authentic concern of all health professions for the good of the patient and the community should be motivation enough to inspire an ecumenic movement toward a unified organization of all the health professions.

Hopefully the health professions will clearly discern the full implications of the challenge posed by the establishment of health care as a civic right. The logical extensions of this mandate cannot be long ignored, or the public will take other means to achieve its goal. Alternatives imposed by public mandate could be deleterious not only to the present situation of the health professions but, more importantly, to health care itself.

In fact, there is no real alternative. Professions are distinguished by ethical imperatives that impel them to higher standards of responsibilty and less self-interest than can be tolerated in other segments of society. If the health professions are to be authentic in the public view, the move to interprofessional cooperation and a unity of perspective and function is an ethical and moral necessity, which implies their eventual amalgamation into a new, larger profession with a single purpose—service to individuals and society. The frustrations and anxieties such a movement portend are more than offset by the enormous benefits that can accrue to mankind.

My suggestions are as follows:

1. That the Physician Assistant conference be limited to members of the profession and approved school educators. This is their conference and should not be meant for any and all interested parties.

2. The conference fee should be nominal $10.00-$15.00 and not to include meals. If the fee is too high many students and new salaried graduates are unable to attend.

3. The session should include professional speakers concerned with medical and or legal orientated lectures.

4. The session should not include panel discussions concerning the various P.A. programs and their curriculum content.

5. I feel that there is a lot of confusion concerning the AAPA-ARPA and the AA of P.A. programs. Maybe a representative of each professional organization could explain the scope and purpose of each organization.

6. I would like to hear about the current status on legislation from an AMA representative.

7. Start the conference off with registration and a social hour the evening proceeding the conference.

8. I would also like to hear a talk or lecture to the P.A. on professionalism in his field.

Thank you for the opportunity to submit suggestions. I hope they might be taken as constructive thoughts and would help in setting up a productive session in Wichita Falls, Texas.