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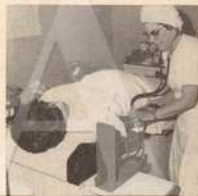


more nondoctors to do doctor work

By Paul W. Kellam
Senior editor, MEDICAL ECONOMICS

They're thinking big in Washington right now about a new kind of physician's assistant as one answer to the doctor shortage. How big are they thinking? For a start, they're talking of increases in the availability of doctor services equivalent to the annual output of all the medical schools in the country. That's pretty big.

"The need is clear, and the potential is there," says Dr. Philip R. Lee, assistant secretary for health and scientific affairs of the Department of Health, Education, and Welfare. "Take pediatrics, for example. At least half of what pediatricians do could be delegated to a well-trained physician's assistant. If you increase the efficiency of all doctors by as little as, say, 4 per cent, you've done the same thing as double the year's output of all the medical schools."

There are obstacles between the now and the then, to be sure—not the least of which are the attitudes of doctors themselves and the attitudes of the bright young people the Department of Health, Education, and Welfare hopes will be attracted by the prospect of lifetime careers as doctors' assistants. Some states severely limit the kind of medical work nonphysicians can do. And compared to careers in the business world, many paramedical jobs now are dull, offer fewer opportunities for independent action, smaller chance for advancement, and generally lower salary levels per year of education and experience.

The first goal of H.E.W. is to find ways to develop a new, more elevated kind of doctor's assistant. He'd work under physician supervision, doing some of the

things doctors now do themselves and freeing them for work that only they can do. He'd partially substitute for the doctor, in effect, though H.E.W. prefers the term "assist."

A number of questions concerning ethics, liability, fees, licensing, and supervision remain to be ironed out, and there aren't any widely applicable answers yet. But the three articles following this one suggest that answers can be found, for MEDICAL ECONOMICS editors discovered examples of non-M.D.s doing doctor-type work with private practitioners in North Carolina, Kentucky, and Illinois.

Defining just what it is that physicians do and which aspects of that can and cannot be delegated is a major first step toward creating new kinds of assistants. The whole problem has been given new emphasis in the report on the nation's health costs recently submitted by H.E.W. to the President.* For the fiscal year beginning July 1, 1968, H.E.W. has requested $373,000,000 for grants to medical schools and other educational institutions. Their projects to develop, demonstrate, and evaluate curriculums for physicians' assistants are expected to get high priority. "In the next year or two I think we'll see a very significant expansion of training programs and attempts to utilize physicians' assistants in a variety of different settings," says Dr. Lee of H.E.W.

Some important effects on the future practice of medicine can be discerned in the comments of Dr. Lee and Dr. George A. Silver, his deputy, on the possibilities they see for non-M.D.s doing doctor-type work. For example:

Physiatry—"What about prosthetics, the training of the patient, the fitting, and so on? Why do all those things have to be done in person by a doctor?"

Obstetrics—"Some say you wouldn't even need a year of training to do much of the work that obstetricians are doing."

Orthopedics—"Why does the orthopedic surgeon have to put on and take off a cast himself in every case?"

Mental health—"That's an obvious area. We'll see physicians' assistants doing a great deal of what physicians used to do—and doing it more effectively."

Ophthalmology—"There's a lot that the ophthalmologist does, particularly in the area of refraction and the fitting of glasses, that the optometrist might do for the ophthalmologist just as well."

Anesthesiology—"I'm sure we'll see the use of paramedics and automated systems, with one physician monitoring several operations."

Geriatrics—"We're already seeing a development of home health-care services, with more nurses and more physical therapists making house calls. Information from these visits can be given to a physician, who can make judgments—whether the patient needs this treatment or that, or whether he needs to come in."

Emergency care—"We can have specially trained assistants in the E.R. who are 'traumatologists,' if you will, functioning either as the general surgeon's assistant or as assistant to the orthopedic surgeon, the neurosurgeon, or the chest surgeon."

In H.E.W.'s eyes, the physician's assistant is to be strictly that, and not the physician's substitute. "He's to supplement and extend the physician's skill and judgment," explains Dr. Silver, "so that this skill and judgment can have an impact on more patients."

*See "Medical Costs: a Report to the President," MEDICAL ECONOMICS, April 3, 1967.

Chances are, though, that the major use of such an assistant isn't going to be in the individual practitioner's office. "The solo practice of medicine is usually an inefficient and uneconomical way of using a scarce skill," says Dr. Silver. "And there's likely to be a serious obstacle to the use of doctors' assistants under a strict fee-for-service arrangement. Should the patient pay the same amount when he sees the assistant as when he sees the doctor? If he pays a lower fee, it may raise a doubt in the patient's mind about the quality of service he's getting."

At the same time, Dr. Silver stresses that care by a physician's assistant would in no way be low-quality care. "The doctor shortage is no excuse for second-class care by non-M.D.s," he says. "We're talking about a system of first-class care. You get that only by organization, so that people concentrate on what they can do best, no matter how many doctors there are per capita. You don't get it by having someone with 12 or 15 years of training doing what someone with three weeks of training can do just as well."

It's plain, then, that when H.E.W. talks about the utilization of physicians' assistants, it's thinking in terms of large-volume, semi-institutional arrangements—group services, rather than individual doctor services. Some spokesmen have described an eventual system in which carefully defined M.D.-type functions, each performed by non-M.D.s under M.D. supervision, are geared to a progressive series of training programs. Candidates for the lowest-rung jobs would be trained quickly and put to work fast, but they wouldn't be pegged forever to that level. Those who display intelligence, skill, strong motivation, and good judgment would have opportunities for additional education to enable them to move up—all the way up,

THE PARAMEDIC OF THE FUTURE *should have true professional status and the opportunity to move upwards in medicine. That's the view of Department of Health, Education, and Welfare planners such as Dr. Philip R. Lee (top), an H.E.W. assistant secretary. "Locking people into lower jobs is one of the great problems in the health-care field today," he says. His deputy, Dr. George A. Silver (bottom), stresses that such mobility wouldn't give nonphysicians license to act beyond their skills. "We're talking about a system of first-class care," he insists.*

theoretically, to the M.D. level at the top. "Locking people into lower jobs is one of the great problems in the health-care field," says Dr. Lee, "and that's what should be avoided as new patterns emerge in the future."

How fast will doctors' assistants come onto the scene and in what quantities? "Those are difficult questions to answer," says Dr. Silver, "because the answers depend upon how well organized physicians' practices become. The more group or institutional practice there is, the more demand there will be for paramedics."

Estimates by the Public Health Service indicate that the health service industry is probably one of the fastest growing in the United States, with the current 3,000,000 workers expected to rise to 5,200,000 by 1975. It's obvious that those 2,-200,000 additional people won't all be doctors.

It's equally obvious that many of them won't be directly involved in patient care, since the crush of patients expected in the future will demand more administrators, housekeepers, and maintenance workers. But it's also clear that—in an expansion of this magnitude—there

A "medic" in general practice

By William W. McClure
Gulf States editor, MEDICAL ECONOMICS

The young woman-patient, an employe of a sewing plant, came to the doctor's office with two deep needle punctures in her hand. The needle had broken off and was embedded well below the skin line. The fluoroscope located the tiny steel shaft, which had missed the bone. A quick shot of Novocain deadened the area, a small incision brought the needle within reach, a couple of sutures closed the wound, and dressing and a bandage completed the job.

Routine treatment of a routine industrial accident, but one thing wasn't routine: Buddy Treadwell, the man in the doctor's office who treated the patient from first examination to final bandage, is not a doctor. He's an "assistant doctor," or "paramedical person," or simply a "medic," depending on what you want to call him—a salaried employe who does doctor-type work. His formal education ended with high school, but he's had 26 years of training and practical experience under Dr. Amos N. Johnson of Garland, N.C., one of the country's best

will be plenty of opportunities for doctors to share their present tasks with non-M.D.s and still keep busy.

So there's a new kind of medicine coming, they declare in Washington, and the nation's needs for more health manpower make its coming inevitable. With it may come fears on the part of some physicians and some patients, acknowledges Dr. Lee. Patients won't be sure they're getting first-class medical care, and doctors won't be either. "The patients' fears will be put to rest," Dr. Lee predicts, "once they see that what's happening is under the direct supervision of a doctor, just as it is in the hospital. The doctors' fears won't be put down so easily, and that's a good thing."

But because there are signs of alarm, H.E.W. is determined to move carefully and without undue haste to define the precise roles physicians' assistants can play. "If we can do this well, the doctor's fears will be put to rest, too," says Dr. Lee. "But I think that in many situations he's still going to have a harder time adjusting to the future than will his patients."

known general practitioners and immediate past president of the American Academy of General Practice.

Dr. Johnson trusts Treadwell implicitly in the areas assigned to him. And the doctor freely admits that his practice wouldn't run nearly as smoothly without such an assistant. "If I didn't have him," he says, "I'd start right now looking for a bright young man I could train to do just what he's doing. I think this type of help is the answer for today's hard-pressed, overworked physician."

Dr. Johnson acknowledges that the arrangement he's developed probably wouldn't work everywhere. "It works in this particular setting because I know my patients, and both my patients and I know my man," he says. "He can do those things I permit him to do as well as I can. If he couldn't, I wouldn't let him."

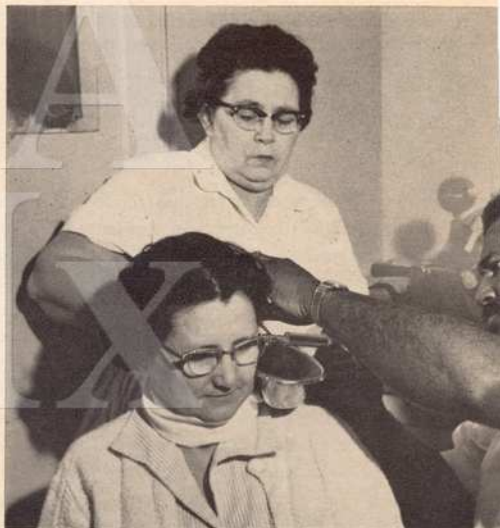
The G.P.'s thriving, small-town practice would likely be judged efficient by most standards. His office hours, to take just one example, are short enough to bring many a harried physician to the brink of envy. He begins a typical day at 8:30 A.M. and, barring emergencies, knocks off for good at 2 P.M. Within that time he sees and treats about 40 patients, who require an appropriate number of urinalyses, blood tests, table examinations, diagnoses, counselings, and prescriptions. In all but diagnosing and prescribing, Dr. Johnson's assistant plays a very important part.

Treadwell's basic function is to save Dr. Johnson's valuable time. When the doctor is in the office, Treadwell handles much of the day-to-day routine. "He works for me much as a resident in a hospital works for an attending," Dr. Johnson says. And by having someone he trusts to coordinate patient care when he's away, he feels free to spend more time at medical meetings or participating in activities of organized medicine.

When Dr. Johnson first sees a patient in his office, the patient is already lying on a table,

undressed for examination, manometer band in place on his arm. Treadwell, in a matter of seconds, reports the results of testing and preliminary examining he's already done—any change in weight, albumin or sugar in the urine, results of other tests if previously ordered, any outstanding symptoms he's noted—and summarizes for the doctor specific complaints the patient has related.

The doctor proceeds with his examination, asking the patient questions of his own, occasionally pointing out something to Treadwell to help him better understand the case. "Listen to the carotid arteries," he'll say, handing over



MUCH AS A RESIDENT WORKS *for an attending, "medic" Buddy Treadwell performs a wide variety of tasks for G.P. Amos N. Johnson, the only practitioner in Garland, N.C. Treadwell is shown here on a typical morning. First he's called on to irrigate patient Anna Russ's ear (above) with the help of nurse Norma P. Carroll. Then he draws blood from Mrs. Elliott Peterson (right) for a blood sugar test. Next come Danny Anders (top, left) for his annual checkup, C. S. Blackburn (center, left) to be weighed before Dr. Johnson examines him, and Mrs. W. T. Bryan (left) to have her fractured radius resplinted after Dr. Johnson has had a look at it.*

the stethoscope. "One's hardening faster than the other. Hear the difference?" Treadwell listens carefully to each side of the patient's throat and nods.

Examination completed, Dr. Johnson makes his clinical decision about what's to be done. He prescribes all medication himself. But at the doctor's instruction, Treadwell routinely prepares and gives injections, inserts catheters, applies splints, takes superficial sutures, and removes stitches. A Negro, he works with white and Negro patients and does certain procedures for female patients, though he doesn't participate in gynecologic examinations. (Dr. John-

How they're training "assistant doctors"

Assuming that the concept of the physician's assistant proves to be a realistic way of attacking the doctor shortage, where is this new breed of medical man to come from? At least one medical training institution—Duke University Medical Center—is already training physicians' assistants. Its first class of three will graduate from the two year course in September, and a second class of 10 will graduate in 1968.

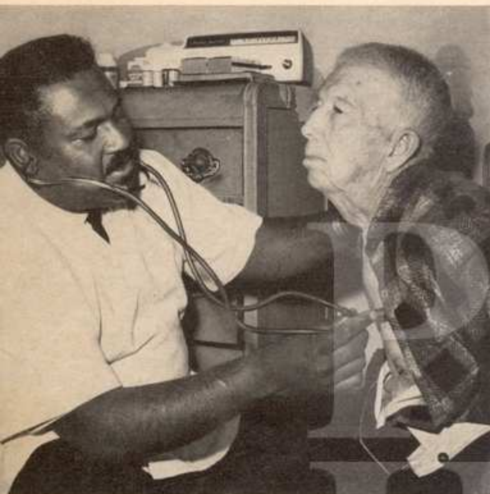
"These students, in effect, will extend the doctor's arms and legs to provide care for more people," says Dr. Eugene A. Stead Jr., chairman of the Department of Medicine at Duke University School of Medicine and founder of the program.

Graduates of the Duke course will be trained to perform such tasks as drawing blood, starting and regulating I.V.s, and intubating the G.I. tract. They'll be able to operate diagnostic and therapeutic instruments like the ECG machine and respirator.

Private practitioners who have watched the high turnover among their nurses and technicians should be interested in the care with which these students have been selected. "Our intent," says Dr. Stead, "is to produce career-oriented graduates." The 13 students presently enrolled are older, more mature, and more sure of what kind of career they want than, say, the average college senior. More than half are married. All but one are male and former military corpsmen who have had a taste of the field.

What kind of salary would a doctor or group in private practice need to pay one of these physician's assistants? No one knows yet, since none has graduated and gone to work. Officially, the school says salary potential "should reflect the ability of trained assistants to increase the earning power of their employer by an amount appropriate to their projected salary." Unofficially, they peg this at a $6,000 yearly minimum, and there's been talk of a $7,000 to $10,000 range, with room to grow.

Apparently, there's no shortage of ex-corpsmen and others who want to enter this new profession. Duke's next class of 10 will be chosen from among more than 300 applicants now trying to enroll in the program.



TREADWELL SAVES TIME *for Dr. Johnson on many out-of-office procedures, too. One of these is making house calls and evaluating patients for home care. Here he examines patient Lennie L. Carter on an evaluation mission, then goes back to report to Dr. Johnson.*

son is helped with those by another assistant, a registered nurse.)

"I don't hesitate to send Buddy out to see certain patients and treat certain conditions in the patient's home," says Dr. Johnson. "I accept his judgment when he telephones back to say that I should come see a patient immediately, stop by at the end of the day, or have the patient brought to my office. He's saved me many a trip into the country that would have broken up an entire morning's office work."

Having an assistant he can rely on more heavily than he could an ordinary aide has been a big factor in permitting Dr. Johnson to participate energetically in activities of organized medicine. During his presidency of the A.A.G.P. he was often out of town, and other medical activities still require considerable traveling (he's a member of the Joint Commission on Accreditation of Hospitals and a past president of his state licensure board). "My assistant is the closest thing to a doctor the town has when I'm away," he says. "He looks after patients I've placed under orders for continuing courses of treatment, and he handles many emergencies, referring those that are serious to nearby physicians who know him well. Minor conditions he'll handle himself."

In certain instances when the doctor is away, Treadwell may exercise medical judgment in areas usually restricted to M.D.s. He follows up on hypertensive patients, for example, checking their blood pressure and regulating dosages of medicine and diets previously prescribed by the doctor. Changes in the amount of medication, however, are limited to *downward* adjustments or discontinuation. Increases have to wait until the doctor is back in town. "However, if stronger or different medication is needed in a

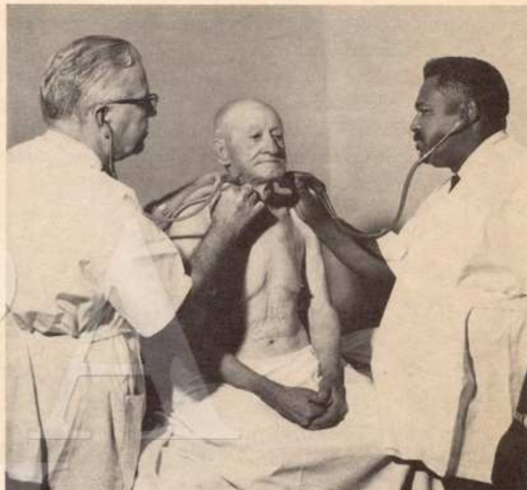
hurry, Buddy would recognize this and have the patient seen by another doctor," Dr. Johnson points out.

Under Dr. Johnson's guidance, Treadwell often handles accident cases. Once he took 40 stitches in a leg that had been chewed up by a chain saw and won the doctor's approval for doing an excellent job. Small emergencies, like the needle in the hand, are taken care of as a matter of course.

"There's a limit, to be sure, and he knows how far he can go," the doctor says. "Accidents that involve repair of arteries or bones are sent 17 miles to the hospital. And except when dire emergencies arise, he never sees new patients. Any who show up while I'm away he refers to other doctors."

The G.P. is aware of the liability risk posed by an assistant so deeply involved in patient care, but he feels it's worth it. "The risk is offset by many advantages," he says, "and I'm willing to accept it. If I practiced in some other part of the country—one of the high-incidence malpractice areas—I'd have to curtail what he does. But it's different here. I've known these people all their lives. Some of my patients are now of the third generation I've treated. They've grown up knowing my assistant, and they trust him. Suing their doctor is the furthest thing from their minds."

What about fees? Do patients expect lower charges when they're treated by a person who's not an M.D.? "I've arrived at a simple way to handle the fee matter," says Dr. Johnson, "and there haven't been any complaints yet. When Treadwell does the work while I'm in the office and directly supervising him, I charge my regular fee—the same as if I'd done the work myself. For procedures Treadwell performs during



KEY TO TEAM'S SUCCESS *is precisely that—they function as a team. At top, Dr. Johnson pauses in his examination of patient Douglas Carter to explain how to identify a carotid artery. And at the bedside of W. T. Bryan, Treadwell summarizes the preliminary exam.*

my absence, the charges are usually reduced by about 50 per cent."

The G.P. pays Treadwell a weekly salary, plus an annual bonus. "It's more than the going rate for skilled labor in the area," he says. Treadwell is also covered by a Keogh plan and, under the terms of the doctor's will, stands to receive a lifetime income if the doctor should die first. As an additional fringe benefit, Dr. Johnson recently purchased for Treadwell 18 acres of farmland adjoining a farm that he himself owns.

Dr. Johnson is obviously satisfied with having

How an R.N. midwife can help

By Howard Eisenberg
Senior associate editor, MEDICAL ECONOMICS

It looked like a long hard night for Dr. Denzil G. Barker of Hindman, Ky. The three labor rooms in the second-floor maternity clinic above the G.P.'s offices were all filled. And a fourth patient with the feeling that she was "about ready for it to happen" lay on a cot in the examining room.

"Well," Dr. Barker told his nurse, "I can't leave the three ladies upstairs. But Mrs. Johnson's at normal term, and it's not her first baby by any means. You'll just have to deliver this one yourself."

Nurse Evelyn Mottram didn't protest, didn't even blink. She simply hurried into the examining room, arranged a sterile setup, and then calmly performed the ancient role of midwife for a 7 lb. 12 oz. baby boy.

It wasn't her first delivery. Evelyn Mottram is a certified nurse-midwife. In the U.S., an estimated 800 like her have delivered thousands of babies, under physicians' supervision, in hospitals and clinics. Nurse-midwives have delivered some 8,000 babies at the Kings County Hospital Center in Brooklyn, N.Y., alone. But the nurse-midwife associated with a doctor in private practice is a relative rarity.

Dr. Nicholson J. Eastman—former obstetrician-in-chief at Johns Hopkins Hospital, who

a trained layman handle many of the varied problems that arise in family medicine. It does not bother him to delegate a good deal of work and responsibility to his assistant. "I don't know any other way a doctor is going to get significant amounts of time for himself," he says. "For me, at any rate, doing things this way has worked very well indeed."

It's hard to argue that point on a crisp afternoon when most of his colleagues are still at their offices, and Dr. Johnson, shotgun in hand, is stalking the Carolina flatlands for quail.

helped sponsor an early hospital-based nurse-midwife school there in 1953—believes that a need exists for a great many more R.N.-midwives both in public and private practice. U.S. maternity statistics support Dr. Eastman's position: There aren't enough doctors to cope with the nation's maternity cases now. By 1975, while the ratio of practicing physicians to patients will have declined from 4 to 9 per cent, live births may increase 25 per cent, to a total of well over 5,000,000 babies annually.

To keep that from becoming an overwhelming total, says Dr. Gordon W. Jones, an obstetrician in Fredericksburg, Va., well over 10,000 nurse-midwives should be trained in the U.S. "to make less thin the obstetrician supply for the next generation." Not, it should be stressed, to take the place of doctors. The American College of Nurse-Midwifery states that its members should work *only* with an M.D.

Dr. Eastman sums up a case for the nurse-midwife with which few doctors could disagree: "I'm not in favor of any substantial alteration in our present program of maternity care. But if just a part of the time-consuming burden of normal obstetrics can be lifted from the shoulders of obstetricians, they will be better able to meet the growing demands."

It was just those growing demands that persuaded Dr. Denzil Barker to invite nurse-midwife Evelyn Mottram to join his staff. There are only two other doctors in Kentucky's Knott County (population: about 17,000), both with offices in the county seat of Hindman. One doctor, now in his 80s, is semiretired and has been cutting back on his practice for years. The other, much younger, suffered a coronary that at least temporarily forced him to stop tending other people's health to attend to his own. Dr. Barker's case load soared and his practice became almost unmanageable.

Many of his deliveries were at awkward times, in awkward backwoods places. Wives of the more prosperous business and professional people in Hindman, who sometimes preferred delivery at Homeplace Hospital in Ary, about 20 miles away, presented even greater problems. With his heavy office practice, Dr. Barker simply couldn't afford the lost travel and waiting time that such deliveries entailed.

Happily, he recalled a New York City-trained R.N. who had come to Kentucky to take the nurse-midwife course given by the Frontier Nursing Service in nearby Wendover. Evelyn Mottram was in love with dollar-poor but scenically rich Appalachia, its people, and

colorfully named towns like Mousie and Hi Hat, Dwarf and Pippa Passes. She wanted to stay on. Says Dr. Barker: "Everything fitted perfectly. There was a vacant upper floor in the building where I've got my offices. I just got out the medical equipment catalogues and mailed in some orders."

Miss Mottram quickly became an integral part of Dr. Barker's practice. As an R.N., she took on office duties and helped with minor surgical procedures. As a midwife, she took on segments of the doctor's OB work—prenatal, postpartum, and, when the doctor was unavailable, deliveries.

When a new OB patient comes in, Miss Mottram spends half an hour taking the initial history, takes the woman's temperature and pressure, weighs, measures, does urine and hemoglobin, even does a preliminary abdominal. Only then does she call the doctor in. He looks at her notes, looks over the patient, and checks fetal position and heartbeat. "All I have to do then is prescribe," says Dr. Barker. "On any 10 OB patients, I figure she'll save me from two to three hours in a day."

As the patient returns for her monthly checkups, nurse Mottram continues to save time for Dr. Barker. More than that, she alleviates unnecessary worries of the mother-to-be. Explains Miss Mottram: "I've found that the nurse-midwife can do a little more teaching,

Could you afford a nurse-midwife?

If you decided to hire a nurse-midwife to help with OB work, you'd have to pay her more than your other employes. The new wage scale in New York City, for instance, is $7,800 to $9,600 a year; for R.N.s it's $6,400 to $8,200 a year. But money may be no object if you're an overburdened practitioner. Sara E. Fetter, consultant in maternal and child health in the Maryland State Department of Health, reports that she has a list of physicians who want to hire nurse-midwives in New Jersey, Delaware, Virginia, and Ohio. "In our conversations," she says, "salary has never been a problem. If a doctor's practice is so large that he needs help, he can afford a nurse-midwife."

The typical request, Miss Fetter says, is from a small-town G.P. seeking relief from his OB burden. "He's probably the only doctor in a community with a hospital of 20 or 30 beds, 10 of them obstetrical, and he carries the entire OB case load in his area. He wants a nurse-midwife to assist him in the hospital and office." One such doctor has worked out a salary-sharing deal with his hospital: The nurse-midwife assists in his office and is also on the hospital staff.

Even a share of this much-sought-after assistant's pay may constitute a considerable outlay. When Dr. W. Newton Long was doing research at Johns Hopkins, he employed a member of the nurse-midwifery faculty there as a part-time assistant in his private OB practice. "I paid her almost as much for her part-time work as I paid a full-time secretary," he says, "but it was a bargain."

2 A.M. CALLS FROM OB PATIENTS *are no rarity for Evelyn Mottram, the R.N.-midwife who assists G.P. Denzil G. Barker in Hindman, Ky. She prepares the patient at his clinic (opposite, top) before waking Dr. Barker to review the chart—and deliver. Then it's back to sleep for Dr. Barker, but the phone tells her another OB is on the way.*

explaining, and advising during the prenatal period than the doctor would ordinarily have time for. Diet advice—around here where the diets are greasy, a lot of them have heartburn—or tips for relieving backaches, for instance." Adds Dr. Barker: "Chances are they'll discuss a lot more things with Miss Mottram than with me. Besides, she can give them specific advice about garter belts and supportive girdles that just isn't in the medical textbooks."

For OB cases, Miss Mottram is on call around the clock. "In fact," says Dr. Barker, "the printed instruction sheets we give our patients tell them to phone her, not me, at the onset of labor. Of course, the excited patient may not always remember that. But I just phone Miss Mottram and ask her to meet the patient at maternity to see if it's true labor. Then I go back to sleep. She handles things from the first stage to the end of the second, at which point she calls me."

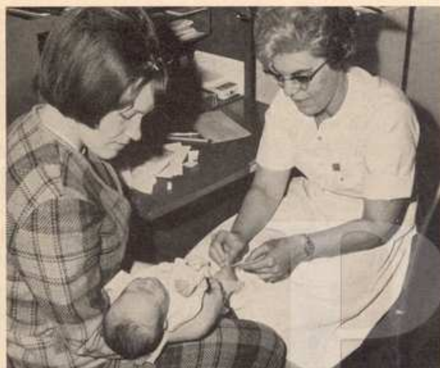
There are times—about a dozen out of the 137 cases the office handled last year—when Miss Mottram must deal with all three stages on her own because the doctor is unavoidably absent. There are cases, however, that Miss Mottram won't deliver. If a patient comes in with a first baby, a previous record of bleeding, or indications of toxemia or complications, she just gets hold of the funeral home's 24-hour ambulance and accompanies the patient on the 20-mile trip to the hospital.

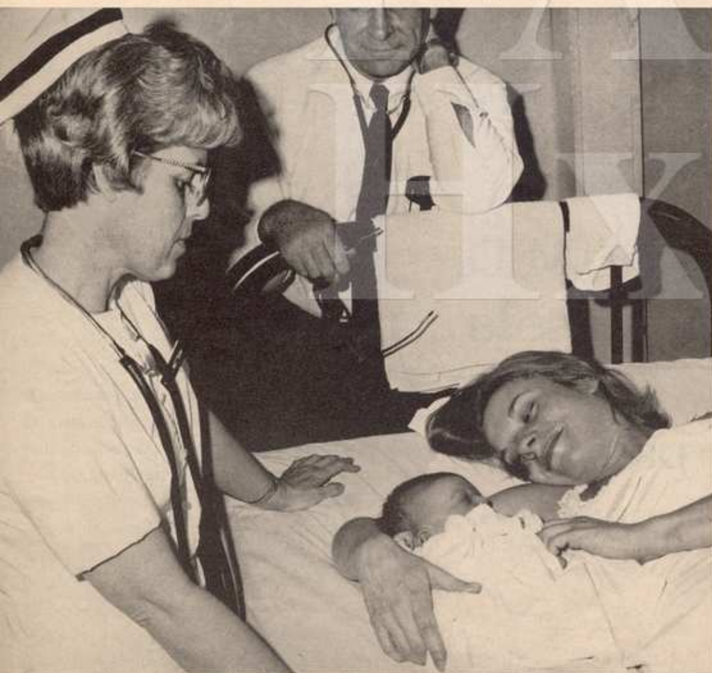
"But suppose it's a normal case and I'm unavailable," says Dr. Barker. "Miss Mottram offers the patient a choice: She'll deliver the child or take the patient to the hospital. She's had such an excellent reputation that far and away the majority ask her to take on the delivery. About the only exceptions are people with Blue Shield, because their policies will pay for delivery only by a physician."

Miss Mottram has had some busy days. "One day when Dr. Barker was away," she recalls, "I delivered two—one at 5 A.M. and the second at 9 A.M." She's had a few tense days as well: "Only twice in my eight years with Dr. Barker have there been cases of excessive postpartum bleeding when I was alone on a case. Both times, I felt it would be risky to keep them in the clinic, in case they went into shock. I took them both to the hospital in the ambulance. Each time, the injection I'd given to help contract the uterus took effect on the way. Neither needed transfusion, and the babies were fine."

What about the possibility of a malpractice suit, had the endings been less than happy?

BEFORE AND AFTER DUTIES *assigned to Evelyn Mottram save Dr. Barker hours daily. Among prenatal chores she handles: history taking, weights and measures, hemoglobin and urine tests, fetal heartbeat checks, and (opposite, upper right) discussing diet and answering assorted questions for patients like Mrs. J. Robert Morgan. Postpartum care includes assisting at circumcisions, preliminaries of six-week checkups, and (upper left) PKU for young Bobby Hall. Dr. Barker delivered Mrs. Maribeth Moore's 1-day-old Susan (opposite). But when he's away, Miss Mottram is in charge. Last year, she soloed—successfully—with a dozen of the doctor's 137 OB cases.*





Says Dr. Barker: "I checked that out with my insurance company long ago, and they told me that policy covers Miss Mottram. I keep my fingers crossed, but actually I can't remember when any physician in this part of the country has been sued for malpractice."

Continuing postpartum care, too, is in large part Miss Mottram's responsibility. She handles Kentucky's statute-required PKU tests on her own, sending them to the Department of Health for processing; she assists Dr. Barker on circumcisions; and she takes care of the routine aspects of the mother and child's six-week checkup—weights, measures, and such. Says Dr. Barker: "All I need to do is look over her notes, make a pelvic check, and recommend treatment. It helps to have the time she saves me to spread around among other patients—especially with all the new ones Medicare has brought in around here."

Two years ago, there were only 500 midwives in the United States. The nine schools of nurse-midwifery have increased that number by more than half. But according to Vera Keane, president of the American College of Nurse-Midwifery, there are still 14 positions open for every nurse-midwife in the U.S. Utah is one of the states now developing nurse-midwife programs—the University of Utah Medical School will graduate its first class shortly—and other areas have schools in the planning stage. Ironically, though, every functioning nurse-midwife school has faculty vacancies, partly because of the nurse shortage itself.

Clearly, if relief is to come to the harried private practitioner from this source, it will be

A non-M.D. counsels M.D.s' patients

By Mary E. Manion
Midwest editor, MEDICAL ECONOMICS

A late afternoon sun slanted into the hospital room where a pale young man, propped up in bed, stared blankly and talked in a low monotone to a bedside listener. The young man had been admitted the night before in a diabetic coma, which he had suffered for reasons not immediately apparent. Now, encouraged to talk, he was revealing signs of a depression that explained the neglect of his medication.

The bedside listener in many hospitals today might be the patient's doctor. But in this case, at Lewis A. Weiss Memorial Hospital in Chicago, the listener was a psychiatric social worker. Many doctors spend a number of hours each week doing what's essentially social work, yet they may not realize the number and va-

a while in coming. And when it comes, his nurse-midwife may still be hampered by multiple state, local, and hospital restrictions on her activities. Perhaps he'll solve them as did Dr. W. Newton Long, who successfully employed a nurse-midwife in his private practice for two years—not for deliveries, but for prenatal care and postpartum hospital rounds. Says Dr. Long: "When Church Home and Hospital in Baltimore questioned my use of a nurse-midwife, I told officials there that the important thing to remember was that if she didn't make rounds for me on Tuesdays and Thursdays, when I was teaching, there wouldn't be any rounds. She was accepted, but with reluctance."

There was no such reluctance on the part of Dr. Long's patients. "I didn't use my nurse-midwife for deliveries," he recalls, "although I did plan to eventually. But patient acceptance of her substituting for me in prenatal care and on rounds was surprising. Out of 300 patients, only three objected, saying they were paying for an M.D. and didn't want a midwife. We took care of them by simply scheduling their appointments for days when I was in the office."

In Knott County, there's no reluctance of any kind. Says Dr. Barker: "Most of the M.D.s doing deliveries in this part of the country would jump at the chance to employ a nurse of Miss Mottram's competency. When she's away on holiday, my wife, who's an R.N., assists me in deliveries. But she's not trained for obstetrical decisions and problems, so I can't allow her that kind of free rein. We both lose sleep when Miss Mottram's away, and we both heave a sigh of relief when she returns."

riety of ways in which a professional social worker could lighten their burdens. The work of Weiss Memorial's director of clinics and social services, Robert T. Cross, offers illuminating examples of such help.

A man with nine years of academic training and 10 years of experience, Cross has a master's degree in social work and over the past seven years has established a solid working relationship with 100 attendings at the 250-bed hospital. A salaried employe of the hospital, he's considered part of the medical team, is invited to all medical staff meetings, and wears the gray jacket customarily reserved for attendings.

Psychological screening is a major chore that Cross takes off doctors' hands. An internist, for example, confronted by a patient with a host of somatic complaints having no apparent physical basis, will refer the patient to the social worker rather than take his own time for an exploratory interview. Cross may decide that he can help the patient by personal counseling. Or he may feel that outside psychological testing is indicated, or that the patient's problem is so deep-seated that psychiatric treatment is needed. After such assessment, he reports back to the internist, usually in person. "I prefer to talk with the doctor personally, so there can be a free discussion about the patient," he explains. "And that also keeps the doctor from having to pore over a mass of written data."

Doctors frequently draw on the social work-

COUNSELING AND PSYCHOLOGICAL SCREENING *are burdens that Robert T. Cross lifts from the shoulders of attendings at Lewis A. Weiss Memorial Hospital in Chicago. A well-educated and experienced social worker, Cross is considered part of the medical team; he even wears the gray jacket usually reserved for attendings. As part of his duties, he counsels patients, as in the top photo with Mrs. Ellin Bressler; reassures anxious mother Mrs. Dorothy Hirsch; arranges to transfer a patient to another hospital; and conducts an informal corridor consultation with Dr. Herbert Bessinger.*

er's exhaustive knowledge of community resources by asking him to handle referrals to other hospitals, institutions, or agencies. For example, a man injured in an auto accident was rushed into the Weiss emergency room, patched up, and sedated. Because beds were tight, the attending asked Cross—who is always on call—to see if another hospital could accept the patient. Starting with identification carried by the victim, Cross did some phone checking, learned the man was an Army private, and found a nearby Army hospital that was willing to admit him.

For an example of the kind of nonemergency in which this doctor's assistant takes over, consider the case of a newborn with a cleft palate. The obstetrician needed only to ask that the parents be referred to the proper agency for help. Cross contacted the agency, explained about the child, and set up an initial appointment. Then he told the parents how the agency could help, gave the mother its telephone number in case a feeding problem or other difficulty developed, and invited her to call him if she wanted further advice.

What in the world should a gastroenterologist do when a young man he is treating for ulcerative colitis begins to indulge in indecent exposure in the hospital corridors? At Weiss Memorial the answer was simple: Call Mr. Cross. Swinging into action, the social worker learned that the man's family had been wiped out in a house fire when he was 5 years old, that he had been under psychiatric treatment on four occasions, and that he was an overt homosexual, although currently somewhat ambivalent about it. After a series of interviews, Cross reported back to the doctor, who decided that Cross should see the patient daily and en-

One M.D. with his own social worker

One physician has found that it pays to have his own part-time psychiatric social worker right in the office. The doctor, internist Leonard P. Caccamo in Youngstown, Ohio, devotes about half his time to cardiology. Many of the illnesses he treats are traceable to the stresses of an unstable home life; similarly, they've discovered that, when a patient is unable or unwilling to follow instructions, the reason is often an emotional problem at home. The obvious solution was to refer such patients to a psychiatrist or community social agency. But what if they resist because of an imagined stigma? When one patient did, Dr. Caccamo discussed the case with Mrs. Margot Wegner, a social worker at his hospital, noting that the situation wasn't unusual in his busy practice. At his request, Mrs. Wegner talked to the patient in the doctor's office—and by so doing helped the patient. That was the beginning of the present arrangement.

The social worker—who has 10 years' experience—continues to see referred patients in the doctor's suite, records summaries of her one-hour interviews in the patient's permanent medical record, and consults informally with the doctor. She sets her own fees, which are collected through the doctor's billing operation with a percentage retained by him to cover her secretarial service and other overhead. Says the highly satisfied physician: "I can't begin to calculate the hours she's saved us, not to mention the help she's given to patients. A doctor who must try to counsel in addition to all his other work can't do the job justice."

courage him to return to psychiatric care. The social worker did, and the patient did. The Cross counseling saved the gastroenterologist at least a full day's time. "This kind of emotional concomitant has to be dealt with," says Cross. "And it takes time—the doctor's time—unless he's willing to delegate this sort of thing."

The same kind of social service saved an internist not only time but serious disturbance. His patient was a 45-year-old housewife who had suffered partial brain damage as a result of a CVA. Following her hospital discharge, she phoned the internist so often that she became a nuisance. Summoned to the rescue, Cross spent five months in helping the woman to adjust to the family problems that had driven her to harass her doctor.

Sometimes doctors leave posthospital planning for their problem patients entirely to the social worker, as in the case of a 55-year-old woman with rheumatoid arthritis and hypertension. The medical judgment was that she must stay off her feet completely after returning home. But she would be alone while her husband was at work, and she couldn't hire help on his modest income. Cross arranged for a homemaker and worked out the financial problem with a welfare agency. The doctor was thereupon assured that she would be able to follow his instructions.

When the psychosocial and medical problems are more intricately entwined, there's a much closer doctor-social worker relationship. A woman recently widowed and left with a disturbed child was unable to cope with the child. As the pressure increased, so did her consumption of tranquilizers. Finally she was admitted to Weiss Memorial in a coma. Her doctor asked Cross to take on the task of persuading her to place the child in an institution. Planning for the child was so intimately involved with the patient's medical condition that Cross and the doctor conferred almost daily to coordinate their joint endeavor.

Doctors also call on Cross to persuade patients who need psychiatric treatment but refuse referral. In time, he's generally successful in overcoming their fears. Sometimes confused patients are referred to him for more detailed explanation and discussion of their illnesses. And he serves as a handy consultant to doctors seeking quick information about community resources, such as how to arrange the adoption of an unwed mother's baby or where to report a case of child abuse.

Naturally, many patients referred to Cross need help in more than one of the many areas he's concerned with. But one factor is common to almost all the patients he sees: While they may have some emotional problems, they also need help to come to grips with concrete financial or social problems. The patient who has strictly psychic problems will be referred to a psychiatrist.

All in all, Cross's experience has convinced him that the social worker's role as doctor's assistant—both inside and outside the hospital—will keep growing.* "Doctors are beginning to accept social service as a profession and the social worker as someone with a real body of knowledge to contribute for the patient's benefit," he says. "The doctor has begun to realize that the social worker, in performing what's normally considered doctor work, represents a gold mine for saving him time." END

*According to a recent survey by the American Hospital Association, 1,151 non-Federal, nonpsychiatric hospitals have social service departments.