FEDERATION BULLETIN

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Howard: "... *the physician's assistant is by no means the whole answer to (the shortage of physicians), but there seems to be no way of ameliorating the situation without relying on the use of the physician's assistant ...*"

Lysaught: "... *I would hope to clarify the role of such a person, determine whether such an individual needs to be developed* AB INITIO *or can be drawn from established manpower pools, and outline the relationships of (the physician's assistant) to related role performers ...*"

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Introduction:

THE PHYSICIAN'S ASSISTANT
Must Ostrichism Continue to Prevail?

Speaking during the 1970 Federation annual meeting, Nathan Hershey, Research Professor of Health Law at the University of Pittsburgh, reiterated his proposal for a moratorium on state licensing legislation recognizing and defining emerging health occupations. However, he continued, ". . . medical boards are going to have to take the responsibility and leadership for changes, not only for those directly affecting physicians, but the entire range of health personnel. . . ." Hershey concluded ". . . I don't see how the medical profession and the members of the medical boards can avoid a major responsibility for the development of the qualification determination process for all people upon whom they rely in providing services. . . ."[1]

Hershey's plea for a moratorium on *licensing* emerging health occupations was supported by the BULLETIN,[2] and the health manpower authorities of the American Medical Association took the same position. However, it was not the intent of the BULLETIN, nor of the AMA, to discourage the development of legislative proposals to allow the certification and registration of physician's assistants.

When Sidney H. Willig, Professor of Law and the Health Sciences, Temple University School of Law, Philadelphia, spoke during the 1971 Federation annual meeting, he emphasized ". . . any board of medical examiners ignoring its rightful role in regulating innovations in physician's assistancy may move to a position of jeopardy and abdication of its legal responsibilities. . . ."[3]

Thus, Hershey in 1970 and Willig in 1971 clearly pointed out the responsibility of state boards of medical examiners for the development of the methodol-

ogy needed in the certification and registration of the P.A. Yet, a mid-1971 Federation survey of the status of legislation pertaining to physician's assistants, even as updated to January 1972, revealed that less than half of the states had taken any steps toward the solution of the P.A. problem with statutory exceptions or specific legislation. In some of these states legislative action was pending. About one third of the states reported the existence of an exception to the medical practice act and/or specific legislation tailored to the local need. Five states reported that proposed changes had been defeated in the legislative assembly. But the boards of medical examiners in about half the states reported neither existing law, pending legislation nor defeated proposals.

Adherence to the *licensing moratorium* concept cannot be considered a satisfactory excuse for what amounts to a degree of *ostrichism*. For, regardless of how much state board members may wish the P.A. would go away, burying their heads in the sands of procrastination will not alter the need to provide a solution to the problem. Thus, state board members are encouraged to become knowledgeable in physician assistancy and work with medical association legislative committees in an effort to hammer out applicable statutory changes. They can give legislative assemblies a reasonable base from which to enact workable measures.

Much can be gained from such pioneering efforts. And there is a great deal to be lost if the vacuum created by medical board disinterest or inactivity in the P.A. area allows the enactment of legislative measures making the certification and registration of physician's assistants a hospital or institutional responsibility.

Throughout 1972, the BULLETIN will feature articles regarding various aspects of the P.A. problem. In this issue, the articles by Howard and Lysaught provide a

solid base of information from which any state board member can launch his search for knowledge about the physician's assistant. Although the articles in this BULLETIN were adapted from presentations made during the 1971 annual meeting of the Federation, they are as timely as tomorrow, and are highly recommended.

R.L.C.

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THE PHYSICIAN'S ASSISTANT AND NATIONAL REGULATION

D. ROBERT HOWARD, M.D.

Introduction

During the past decade the health services industry has witnessed the emergence of a new health professional as a natural and evolutionary response to societal demands. No longer can the fact be ignored that society demands medical services for all, regardless of financial status. It is rapidly becoming essential that we provide not only the traditional *medical* services, but comprehensive *health* services as well.

Times have changed, technology has changed, knowledge has changed, and the role of the doctor has also changed. The notion that the doctor today is and must be the sole vendor of personal health services is a fantasy! In the well-known words of Tennyson: "The old order changeth, yielding place to new. . . ."

Admittedly, many of the more unreasonable demands of the present are the result of cheap political opportunism and we must do everything in our power to make people realize that there is such a thing as too much medical care. However, we must also realize that as a service industry, our primary responsibility is to provide service. Making people aware of the limitations of our service capabilities and understanding what kind of services will be most beneficial to them are only secondary responsibilities. If we lose sight of our priorities, we will go the way of the railroads and soon be dependent on someone else to chart our course.

It is evident to all of you here that many, perhaps most, doctors simply cannot work any harder. Obviously, then, in the light of increasing demands, the

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doctor's role must change. In the past he has resolved the problems of overwork by delegating certain responsibilities to non-physicians. First nursing, and subsequently all the allied professions have evolved in this manner.

In order to create a person able to assume functions that are still traditionally performed by the doctor, several basic principles are essential. First, to communicate effectively with the doctor, a person of this type must be able to understand, speak, and write the same medical language; second, to protect the patient's safety, he must have a broad understanding of medicine and its related sciences; third, to be professionally functional, he must be accountable to the doctor and have the same temporal flexibility and geographic mobility; and fourth, to be professionally accepted, he must be able to assume responsibilities that are part of the *doctor's* role and which are *not* the responsibility of other allied health professionals.

D. Robert Howard, M.D.

About ten years ago, specialists at Duke Medical

Center, who were concerned with the application of new diagnostic and therapeutic procedures, found they could safely delegate many repetitious functions to non-physicians. Because of the scarcity of nurses and trained technicians, these doctors relied largely on the ex-military corpsmen who had had previous education and experience but who did not fit readily into the civilian health care system. At about the same time, the plight of the community based practitioner was reaching a critical state. In 1965, Dr. Eugene A. Stead, Jr., who was then Chairman of the Department of Medicine at Duke, decided to see if the solution for one problem could not be effectively modified to solve the other. The result was the physician's assistant.

During the past five years the term "physician's assistant" has taken on a variety of meanings and in the literature the problem of definition has been compounded by an almost indiscriminate use of other terms such as ancillary, auxiliary, assistant, associate, allied, affiliate, paramedical, and surrogate. Physician's assistant programs now exist that range from four weeks to five years in length. Their graduates do everything from changing the paper on an examining table to heart catheterizations and bowel biopsies. On one end of the personnel spectrum, orderlies exhibit insecurities when confronted with "physician's assistants" and at the other extreme, many doctors and nurses feel threatened by their presence.

Definitions

In an effort to define just what a "physician's assistant" really is, one must take into consideration the action by the American Medical Association's House of Delegates at their last meeting, when they officially defined a physician's assistant as "a skilled person qualified by academic and practical on-the-job training to provide services under the supervision and di-

D. Robert Howard, M.D., Director of the Physician's Assistant Program at Duke, is Chief of the Division of Manpower Training, Department of Community Health Sciences, at that North Carolina university.

A native of Chicago, Dr. Howard left the Windy City early, earning his baccalaureate degree and his M.D. at the University of Wisconsin, Madison. There, at the Madison General Hospital, he completed his internship. Subsequently, he held staff appointments at a number of hospitals in that city.

Completing U. S. Air Force duty in 1968, he began his academic career at Duke as an Associate in Community Health Sciences. Obviously, his decision to seek involvement in the academic world was a propitious one. For, in the past four years, he has been catapulted to a position of national recognition as a leader in the training of physician's assistants, through the Duke program.

Widely sought as a speaker at medical meetings from coast to coast, Dr. Howard also has become a prolific writer, author or co-author of numerous articles in a number of local, regional and national medical journals. Although the titles to his articles reveal some evolutionary changes, in much the same manner that the P.A. training programs have evolved, generally the topic has been the physician's assistant.

A member of the AMA and the Wisconsin State Medical Society for a number of years, he now lists his medical society affiliations as North Carolinian. A Diplomate of the American Academy of Family Practice from 1970, he has been a member of the North Carolina and the American Academy of General Practice from 1968.

As a native of Chicago, educated in America's Dairyland state, none would mistake him for a native of the area below the Mason-Dixon Line. However, for those interested in such things, Bob Howard served the two years immediately preceding his appointment to the Duke faculty at the Columbus Air Force Base, Columbus, Mississippi.

rection of a licensed physician who is responsible for the performance of that assistant." This does resolve many of the grey areas in that it implies that accountability is to a *physician* and not to an *institution*.

In examining the traditional health professions, one

finds several common denominators that set them apart from the physician's assistant. Certainly there are exceptions, but by and large people in other allied health professions are accountable to institutions or work in geographically fixed locations. Their functional involvement is limited to the *care or treatment* of patients, the *technical* or *laboratory evaluation* of patients, or *supportive services*. They do, however, perform in both specific and/or nonspecific roles within a wide range of knowledge and skill levels. However, not until the evolution of the professional physician's assistant has the doctor had a helper accountable to him to provide services in the area of *patient evaluation*. It is this relationship and this function that distinguish the physician's assistant.

As with other health professional groups, physician's assistants function across a wide spectrum of knowledge and skill. In an effort to resolve some of the confusion associated with a poorly delineated range of performance levels, the Board on Medicine of the National Academy of Sciences investigated the development of this new concept and defined three major types of physician's assistants. The three designated types according to their classification are:

> The Type A Assistant, who "is capable of approaching the patient, collecting historical and physical data, organizing these data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic and therapeutic steps. He is also capable of assisting the physician by performing diagnostic and therapeutic procedures and coordinating the roles of other, more technical, assistants. While he functions under the general supervision and responsibility of the physician, he might, under special circumstances and under defined rules, perform without the immediate surveillance of the physi-

cian. He is thus distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment."

The Type B Assistant, who "while not equipped with general knowledge and skills relative to the whole range of medical care, possesses exceptional skill in one clinical specialty or, more commonly, in certain procedures within such a specialty. In his area of specialty, he has a degree of skill beyond that normally possessed by physicians who are not engaged in the specialty. Because his knowledge and skill are limited to a particular specialty, he is less qualified for independent action."

The Type C Assistant, who "is capable of performing a variety of tasks over the whole range of medical care under the supervision of a physician, although he does not possess the level of medical knowledge necessary to integrate and interpret findings. He is similar to the Type A Assistant in the number of areas in which he can perform, but he cannot exercise the degree of independent synthesis and judgment of which Type A is capable."

Because the term "physician's assistant" has been applied to all three categories, it is evident that a more definitive nomenclature is needed. Several centers involved in the education and training of Type A Assistants are in the process of changing or have already changed their program titles to "Physician's Associate." Thus, anyone functioning in the role of the "Type A Physician's Assistant" as defined above would qualify for the title of "Physician's Associate." Because physicians usually practice within a defined specialty, be it general or family medicine, internal medicine, cardiology, pediatrics, surgery, any other of some thirty recognized specialties, and because it would be inappropriate for an "assistant" of this

type to be supervised by a physician who lacks the appropriate clinical expertise, it seems reasonable for these people to be classified as "Physician's Associate —(some specialty)" such as "Physician's Associate—Family Medicine," "Physician's Associate—Surgery," or "Physician's Associate—Cardiology." This would assure proper matching of the physician and associate.

The concept of the Type B Assistant progressed to a similar point of clarification several months ago with recognition by the American Medical Association and other groups within organized medicine of the "Specialty Assistant." To date, the development of the orthopedic assistant, the ophthalmology assistant, the urology assistant, and the pediatric assistant has already been formalized. Here, too, the assistant is matched with the specialist, but the scope of his activity is more limited than that of the "Associate."

The Type C Assistant, who "is capable of performing a variety of tasks over the whole range of medical care under the supervision of a physician" really does not represent anything new but rather implies the application of general medical knowledge possessed by many of the traditional health professionals with accountability changed from an institution or specific location to a physician. He might progress to a higher category through additional training or experience in the area of patient evaluation.

Hereafter I shall make no specific reference to the Type C Assistant. The Type B Assistant will be referred to as the "Specialty Assistant," and the Type A Assistant as the "Physician's Associate." Further use of the term "Physician's Assistant" will refer to any or all groups.

Selection of Students

The next issue I should like to discuss relates to student selection. At Duke it has been evident that in addition to the ex-military corpsmen there are many persons functioning in the institutionally ac-

countable health professions who feel they would have greater career satisfaction as a physician's assistant. To date, and for various reasons, the selected applicants have come from these two groups. First, they possess an understanding of problems associated with the delivery of health services; second, they are acquainted with the peculiarities of sick people; and third, they are mature, stable people who are highly motivated. If any of the existing Physician's Associate or Specialty Assistant type programs were to rely on "raw recruits" the length of training would have at least to be doubled.

A specific profile of the matriculating students is difficult if not impossible, because of the wide variation in their backgrounds. The students in our last class ranged in age from twenty-one to over forty years. A few had not progressed beyond high school but some came with more than six years of college. The average combination was between two and three years of college plus five years of health related experience. The "average" student is twenty-eight years old, married, and has two children. Because applicants of this type can point to past accomplishments, and because there seems to be no end to the number of people with comparable backgrounds, it is not necessary to think of deviating significantly from these selection criteria.

Courses of Instruction

The current 1,100-hour general, didactic, first-year curriculum is directed toward providing the students with a comprehensive understanding of the basic medical sciences. In this phase of their education, the students are taught the history, philosophy, and ethics of medicine; basic clinical pathology; medical terminology; epidemiology; bacteriology; anatomy; physiology; essentials of chemical biology; clinical medicine; pharmacology; clinical chemistry; animal surgery; fun-

damentals of electrocardiography; introduction to radiology; computer medicine, human growth and development and patient evaluation. Many of these subjects are taught in somewhat less depth than at the medical student level, but physician's assistant students use the same books as the medical students, they are taught in the same environment as the medical students, and their teaching is done primarily by doctors. It is during this very demanding phase of the curriculum that the need for previous knowledge and experience is most evident. Some portions of the first year material are repetitious for all of the students; but, because of the spectrum of backgrounds, this is seldom the same for any two students. If some of the material were not repetitious, it is unlikely that a student would be able to absorb such a vast amount of material in such a short time.

Following the initial basic science portion of the course, the students enter a fourteen month clinical experience, in which they learn to apply the core of general medical knowledge acquired during the first year. Initially, our emphasis was exclusively on the area of general or family medicine, but as physicians in other specialties expressed interest in the employment of assistants in their own practice settings, it was decided to expand the scope of the program to include internal medicine, surgery, and pediatrics. This expansion has been continued so that now students are being trained in most of the clinical specialties including industrial medicine, radiology, and pathology.

Of the fourteen months of clinical experience, half is devoted to required and half to elective activities. All students (with the exception of those in radiology and pathology) spend two months on an inpatient service, two months on an outpatient service during the day and in the emergency room during the evenings, and one month each in an intensive-care set-

ting and in one of the departmental health clinics. In addition to these experiences, the student selects three, two-month elective rotations of his choice.

At the conclusion of the twelve months of clinical teaching in the medical center, the students serve a two-month clerkship with a community-based physician so that their educational background can be expanded by having the opportunity to learn the multitude of problems with which the practicing physician is confronted.

Legal Problems

Because of time limitations, I can cover only a few of the many issues related to the use and role of physician's assistants, but it seems fitting here to discuss the legal issues related to this new profession, at least as we see them. The reason why legal questions arise is that at present virtually all health personnel who perform any responsible functions are licensed to do so. Until recently, physician's assistants were not licensed or otherwise formally recognized in any state, and many people were concerned about the dangers of civil or criminal liability. Because physician's assistants perform many tasks which have traditionally been performed by physicians themselves, this raised a question in some people's minds as to whether the physician's assistant is practicing medicine without a license and whether the physician is therefore aiding and abetting the illegal practice of medicine.

As far as civil liability is concerned, the physician is held responsible for negligent actions of anyone in his employ or, in some cases, for the actions of people who, though employed by another, are acting under his direction. This type of civil liability, based on the theory that the master should be responsible for the acts of his servant, inheres regardless of whether the personnel are licensed. We feel that such liability is desirable when actual negligence is involved, and we

would not seek to change this situation, but the possibility of an additional type of civil liability exists when the physician delegates tasks to personnel not officially recognized.

In one case, Barber v. Reinking, the court allowed an inference of negligence to be drawn from the mere fact that a task was delegated to a person not licensed to perform it. The theory of the case apparently was that the legislature, by establishing a licensure scheme, had determined what was permissible, and that any activity outside the licensure specifications was presumptively negligent. Even though the danger of civil or criminal liability based solely on the lack of formal recognition might be slight (except perhaps in the few states with a high incidence of malpractice litigation), if physicians are concerned over the possibility, they may be reluctant to make the most effective use of physician's assistants.

Because of this concern, for the past few years one of our areas of concentration has been on the legal situation and possible means of clarifying it. We were assisted in this effort by a contract from the Department of Health, Education, and Welfare. The object of the project was to develop a model legislative proposal which would insure the legality of the physician's assistant's performance while at the same time giving assurance that the patient's welfare was safeguarded. As part of the project we held two conferences at Duke and engaged in extensive correspondence with our participants, particularly those with experience in medico-legal matters.

At the first conference, possible ways of accommodating physician's assistants into the health care system were discussed in great detail. Since most other members of the health team are regulated through licensure, this was the obvious first alternative to be considered. It was, however, rather quickly rejected by the participants. The principal reason for reject-

ing this approach was the feeling that the licensure might interfere with the efficient delivery of health care. Licensure laws by definition specify in more or less definite terms the scope of practice permissible for a particular group. If the scope is precisely defined, the chances are that it will be obsolete practically from the time of the statute's enactment.

New technical devices are bringing more complex tasks within the capability range of sub-physician personnel at such a rapid rate that no rigid definition can possibly keep pace with reality, given the delays and vagaries of the legislative process. In addition, differences in practice settings require that personnel with the same basic background perform in vastly different ways. Licensure laws not only often inhibit this, they also hold back experiments designed to determine how particular types of manpower can be used to increase the efficiency of the system.

If the practice scope is defined vaguely rather than precisely, there is much uncertainty as to whether particular functions fall within the definition, with concomitant and unnecessary legal risks. In one way or another, licensure laws appear to have frustrated the use of personnel in ways most effective and realistic in particular settings. Licensure appears to be particularly inappropriate for the physician's assistant, since flexibility, allowing responsiveness to the needs of the supervising physician, is truly essential if the physician's assistant is to function most effectively. It would be virtually impossible to write a licensure "scope of practice" which would be realistic for all the various practice situations.

Although the physician's assistant is given adequate basic knowledge in his educational program, it is anticipated that because of the close relationship with a supervising physician, his learning and development of new skills will continue throughout his professional career. A reasonable scope of practice for a

recent graduate would almost certainly impose unjustifiable restrictions on physician's assistants with ten years of experience. Similarly, a person assisting a cardiologist will develop different types of skills than one assisting a surgeon. Any law which prevents responsiveness to the particular situation would be dysfunctional.

In addition to licensing physician's assistants, consideration was given to the feasibility of granting a special license to physicians who wish to utilize physician's assistants, and the enactment of a general statute making it clear that physicians can delegate tasks to assistants as long as they exercise direction and supervision. The approach ultimately favored has elements of all three of these alternatives and was developed in response to two ideas which dominated the discussion at the conferences.

First, the participants recognized that because the physician's assistant concept is still relatively new, the limitations and potentials of these assistants are not yet clearly and firmly established. The consensus was that any legislation should provide for as much flexibility as possible consonant with insuring patient safety. The other dominant idea was that because the physician's assistant works in close relationship with the physician, the physician is in the best position to know the extent of his competence and should be relied on as the primary regulator of his activity. The legislative proposal itself is cast in the form of an amendment to the state's medical practice act.

The conference consultants proposed that an exception be added to cover any act, task or function performed at the direction and under the supervision of a licensed physician by an assistant to the physician, if such assistant is approved by the board of medical examiners and acts within certain general guidelines established by that board. Such a legislative change would establish basically a two-stage

regulatory mechanism to insure the quality of the physician's assistant's performance and consequently the safety of the patient.

No attempt is made to define a scope of practice or list the permissible activities for the assistant. The basic idea is to leave the decision as to what an individual physician's assistant can do up to his employing physician, who is realistically in the best position to make an up-to-the-minute evaluation of his skills and competence.

The physician, under traditional master-servant principles, is legally liable for the acts of his physician's assistant, and this will impel him to exercise such discretion as is necessary to protect the patient. This is a more effective insurance of quality than is currently provided through licensure boards, which generally evaluate a candidate only once during his entire career or at best only periodically and often not in a manner well designed to measure his competence in the tasks he in fact performs each day. The physician, then, under our proposed legislation accepts primary responsibility for evaluating the competence of his assistant and for seeing that the assistant's activities are determined in accordance with his abilities.

Several conference participants did not consider it advisable, however, to rely exclusively on the individual physician in regulating the assistants. They felt that organized medicine, as represented by the state's board of medical examiners, should have some voice and the power to step in when there is a situation of abuse.

The second stage of regulation under our proposal, therefore, is in the hands of the board of medical examiners. To enjoy the protection afforded by the statute, the physician must apply to the board for approval of his assistant.

Again, the board would not be expected to define

practice scopes for the various assistants, that being the province of the physicians. It would, however, be able to revoke its approval and therefore terminate the protection of a particular assistant and physician if it appeared that proper care had not been exercised in restricting the assistant to his areas of competence or in supervising his activities. The board would also be empowered to enact certain rules and regulations establishing general guidelines for the performance of the physician's assistant. An example of the type of regulation anticipated might be a requirement that a physician's assistant be clearly identified as such to avoid the possibility of the patient's confusing him with a physician.

A more immediate effort to achieve some standardization and recognition for the "Type A Physician's Assistant" has been the development of the American Registry of Physician's Associates. This organization has assumed as its premise the guidelines and criteria for training Type A Physician's Assistants as outlined in the National Academy of Sciences report and its membership is comprised of representatives from the institutions currently training this type of assistant.

The objectives and purposes of the organization are:

1) To encourage the training and to promote and regulate activities of Physician's Associates;

2. To elevate the standard of Physician's Associates by improving their training;

3) To determine the competence of Physician's Associates and to arrange, control and conduct investigations and examinations to test the qualifications of voluntary candidates for certification by the organization;

4) To grant and issue certificates of registration to graduates of approved educational and training programs who voluntarily apply therefor, on the basis of these credentials and/or an examination; and to main-

tain a registry of holders of such certificates;

5) To grant and issue certificates of registration to other persons who voluntarily apply therefor, who demonstrate, by examination, that they possess a background of training and experience indicative of an ability to perform satisfactorily in like manner as graduates of approved programs;

6) To serve physicians by preparing and furnishing lists of Registered Physician's Associates who have been certified by the organization.

It is anticipated that when the American Medical Association or some other national accreditation group develops educational guidelines and assumes the responsibility for accrediting and approving programs of this type that these functions of the registry will be dropped.

In conclusion, it seems safe to say, on the basis of evidence to date, that the professional physician's assistant, as an integral member of the manpower team, is here to stay. As might be anticipated, several varieties of physician's assistants have evolved to fill different needs in different types of practices. Although some focus has been achieved, problems associated with definition will be present for many years until substantial experience with large numbers has been gained.

Several things about physician's assistants are quite clear, however. This concept adds a new dimension to the participation of non-physicians in the delivery of health services. Addition of relevant knowledge and skills to one who has had previous experience in the health system results in a competent and effective member of the health team. Reliance on students with a background including experience and formal education provides an opportunity for career advancement in areas other than administration and education and thus can help overcome the dead-end characteristics that have discouraged many from

seeking careers in the health industry and, worse, driven many to quit out of frustration.

The professional physician's assistant, be he a physician's associate or specialty assistant, is a true professional who must dedicate himself to a career commitment unregulated by a clock. His productivity is directly related to his versatility which depends in turn on a unique combination of experience and education. His effectiveness is related to his geographic mobility and the intimate relationship he develops with a physician. In the next decade, a myriad of problems in the delivery of health services will have to be resolved. One of these relates to the shortage of physicians. The physician's assistant is by no means the whole answer to this problem, but, on the other hand, there seems to be no way of ameliorating the situation without relying on the use of physician's assistants.

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THE NATIONAL STUDY OF NURSING AND NURSING EDUCATION AND ITS RELATIONSHIP TO THE CONCEPT OF THE PHYSICIAN'S ASSISTANT

JEROME P. LYSAUGHT, Ed.D.

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

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

In the months since the appearance of the final report, a number of actions have taken place. First, the Kellogg Foundation has enthusiastically agreed to fund

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an implementation phase to facilitate the adoption of the changes recommended. This has been followed by endorsement of the report by the American Nurses' Association, the National League for Nursing, and the Committee on Nursing of the American Medical Association. Moreover, an *ad hoc* committee named by the American Hospital Association to study the report has reacted favorably to the central thrust of the recommendations, and still other professional bodies are now engaged in various phases of examination and reaction.

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

It was the openness and the objectivity of the approaches, further detailed in *An Abstract for Action*,

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

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

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

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The Emergence of the Physician's Assistant Concept

The growth of interest in, and actual development of preparatory programs for, physician's assistants has closely paralleled the time line of our nursing investigation. It can be reasonably inferred that the underlying problems which caused national concern for the future of nursing sparked the interest in emerg-

ing health occupations. Among the trends that have evoked particular pleas for change are these:

1) *The Rising Need for Care.* A steadily expanding population coupled with increased concern for the inclusion of previously neglected societal segments has brought our entire health care system to the breaking point under sheer "people pressure." Even with a reduction in the birth rate, the increased base will provide vast numbers of new infants who require proportionately more than average amounts of health care. Additionally, the very success of our health care system has increased life expectancy, and, concomitantly, the numbers of our geriatric and domiciliary patients beyond all past experience. Again, these individuals require more than average amounts of care. To meet these demands, it requires little prescience to recognize that we need more hands. It may, however, be important for us to deliberate on what those hands are required to do and how skilled they must be in order to minister to the patients' needs.

2) *The Changed Economics of Health.* Accompanying the rise in demand for care is a fundamental change in the economic structure of our health system. Most analysts agree that, by 1975, 100 per cent of our population will be covered (for all practical purposes) by some combination of public and private insurance systems. The short and middle-range effects of such a development are bound to increase demands—now fortified with the assurance of prepayment—on an already creaking health system. Add to this the fact that more Americans, encouraged by their insurance for basic care, are spending increasing proportions of their discretionary income on cosmetic or marginal care, and we have the specter of demand almost choking the supply of health care through our present schema.

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

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

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

personnel, separately named, separately trained. It is in this domain that the report of the National Commission has particular relevance.

The Paradox of Nursing

It is likely that the confusion of roles and planning begins with the very paradox of nursing itself. For one thing, the public and the health professions, even nursing itself, are conditioned to the existence of a nursing shortage. And these many individuals could scarcely be criticized for neglecting nursing in the consideration of changing roles in health care if they perceive the profession as being unable to fulfill its own manpower requirements.

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

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

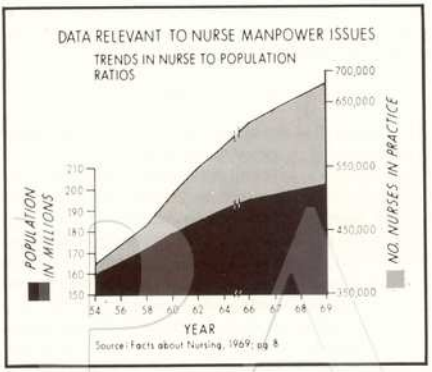

Figure 1

and was able to increase the ratio of doctors from 141 to only 150 per 100,000.

Any enthusiasm over this occurrence is rapidly chastened, however, when we examine the withdrawal rate from the nursing profession. While we have certainly increased the numbers and ratio of nurses in practice, we have suffered sobering losses from the potential numbers we might have attained. In figure 2, we can see the "staying power" of nurses in professional practice. One out of every four is totally inactive; another 25 per cent is active only to the extent of maintaining licensure; of the remaining 50 per cent almost one out of every four (and this percentage is increasing) is only a part-time nurse. Of more than 1,300,000 graduate nurses, approximately 450,000 are employed full time. This figure, of course, includes nurse educators, administrators, supervisors, and all manner of practitioners.

Nor is the rate of inactivity the only disturbing evidence of trouble within the profession. Approxi-

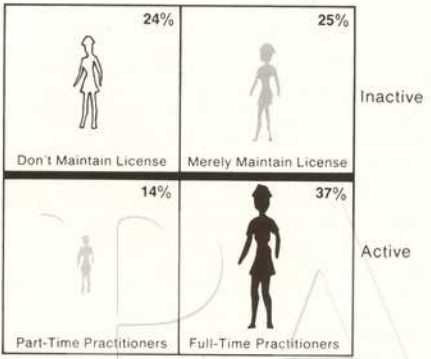

Figure 2—Distribution of Activity Among Graduate Nurses

mately one out of every three students who enter any kind of preparatory program in nursing drop out before completion of their program. Not only do nurses display a greater rate of withdrawal from their profession than any other group of women with similar education and training, but the average rate of turnover among staff nurses in American hospitals is over 70 per cent while the rate of turnover among elementary and secondary teachers—also predominantly female and from the same socio-economic backgrounds—is approximately 20 per cent. Finally, there has been a slow but steady decline in the percentage of high school graduates selecting nursing as an occupational choice.[6]

As indicated by the brief comparisons to other "women's groups," it is inaccurate and misleading to explain these problems by the mere statement that nurses are women and that is that! At the risk of oversimplification, our three-year analysis of these complex problems wholly corroborated the argument of

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

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

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

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

Social reinforcers may be viewed as being either extrinsic or intrinsic to the basic needs of the indi-

vidual. Extrinsic reinforcers, such as pay and benefits, can provide for the basic survival and security needs of the individual as suggested by Maslow.[8] Such a formulation suggests that until the basic needs of the individual for a living wage and reasonable economic security have been met, it is generally useless to appeal to other motives as a springboard to action. That there are evident economic concerns over nursing compensation is widely recognized. The emphasis of the nursing organizations on economic security, the increasing militancy of bargaining, and the growth of the entire "fem lib" salary protest dramatically score the need to provide more reasonable levels—and prospects—of compensation. Parenthetically, however, I would state that our economic problems are the most easily solved despite their complexity. Our genius for business in America, and the structure of our modified capitalist society, suggest that we are geared to handling the salary and compensation matters once we really tackle them.

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

The point to conjure with is whether there are indeed some intrinsic satisfiers in nursing that could not only provide a long-range solution to its manpower problems, but contribute to the revitalization of our health care system. The answer may be so simple and direct as to be overlooked. If we examine the abundant evidence of Hughes[10] and others, we will recognize that the primary reason for entering nurs-

ing at all is expressed in the desire "to help people." This would suggest in pretty straightforward fashion that the individuals themselves identify as behavioral reinforcers those activities related to direct patient care functions and, very likely, the ability to increase systematically the quality of such personal activity.

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

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

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

search findings. Perhaps the Commission philosophy is best summed up in their statement that . . .

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

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

Relationship to the Physician's Assistant

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

The chairman of the AMA Committee on Nursing, Dr. Charles Leedham, points out: "The nurse is the logical individual to support the physician in the management and care of the patient. This support is broadened as nursing moves into the age of specialization. This thrust toward an expanded role supports the desire expressed by the nursing profession for more significant role responsibilities. An enhanced role for the nurse will enable the physician-nurse team to better meet the challenging demand for

more adequate delivery of health care to the entire population."[13]

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

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

Now, it may be that my concerns over the physician's assistant are entirely groundless. That is, the new occupation may not function to stifle the natural development of the nursing role and the career perspective of that profession. As a matter of fact, the variety of programs labeled as preparatory for the physician's assistant makes it difficult, I know, for us to analyze precisely what we mean by the term. But this brings us to the point that the public interest, the need for interdependence in professional role per-

formance, and our own need to function effectively argue against another experience of "muddling through" the problem. To this end, the National Commission has a proposal that I think is critical for all our sakes. The Commission recommends that we begin to think and plan first, then act in accordance with consensual decisions. Specifically, we propose that:

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

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

Through national and state counterpart committees we could begin to resolve the functional and jurisdictional problems that have beset us for too long—and hopefully prevent their proliferation and re-occurrence. Let me emphasize in this regard that I do not anticipate that such commissions would reject the concept of the physician's assistants. Rather, I would hope they could better clarify the roles of such a person, determine whether such an individual needs to be developed *ab initio* or can be drawn from estab-

lished manpower pools, and outline the relationships of such a person to related role performers.

Related Administrative Matters

While we wait—and I use that term emphatically—for concerted proposals from the Joint Practice Commissions for the future development of congruent roles and professional responsibilities, the Commission feels strongly that we should retain our current licensing regulations in nursing, that is, a single license attesting to minimal skills for safe beginning practice. The certification of advanced clinical practice, specialization, and other recognized levels of professional competence should for now be left to professional—or inter-professional—boards. We recognize that the decisions which come from the Joint Practice Commissions will have a decided impact on the health practice laws of the several states since it seems inevitable that nursing will assume both more responsibility and liability for individual practice in all kinds of settings. We have already had experience in more than half the states with the formulation of joint statements on practice which have affected either state practice acts, or their specific interpretation. Likely, the emergent roles will require more fundamental reconstruction of governing legislation than can be accomplished by simple amendment or rulings.

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

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