Certification — Assurance of Quality

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Nurses throughout the nation are increasingly raising questions about the certification program of the American Nurses' Association. What is the purpose as well as the nature of the program? Why do we need it? And what will be its ultimate effect?

The need for certifying the practitioner has existed for a long time; and it has intensified over the years. Historically, certification has served the purpose of declaring an individual officially qualified to perform certain tasks and functions. In recent times, a marked trend among professions has been the establishment of certification programs designed to identify members who practice on a level higher and more sophisticated than that determined by state licensure examinations. The development of these programs has been greatly influenced by the emergence of a more enlightened consumer who demands quality in modern health care.

Professions have been considered accountable by the very nature of their being; beyond that, no documentation was expected. However, as society became more complex, the validation of the quality of professional services became a major concern; and the issue of accountability assumed new dimensions.

It is now an expectation of the public that nurses document the quality of health and illness care and that they demonstrate this quality through specific processes of accountability. One process deals with an individual's specific qualifications and is called certification.

ANA Certification Program

Certification programs respond to one major demand by society: to validate quality performance. Thus, the principal and central focus of the ANA certification program is one of quality assurance. By becoming certified, a nurse can demonstrate that *she has achieved a level of performance which allows her to validate qualifications for rendering specialized nursing care of high quality.*

In addition to its chief purpose, there are other reasons for certification. One is to identify nurses whose services may be individually reimbursable through federal and state monies. There is no question that it will be easier to seek reimbursement for nursing services which are provided by certified nurses.

Certification also aims to recognize individual achievement and quality of practice. It is a process whereby a nurse receives recognition from her peers for the performance of nursing care reflecting quality and accountability.

At its fall meeting in 1977, the ANA Interdivisional Council on Certification (a body consisting of representatives of the executive committees of the ANA divisions on practice and their respective certification boards) unanimously adopted the following definition of certification:

> Certification is the documented validation of specific qualifications demonstrated by the individual registered nurse in the provision of professional nursing care in a defined area of practice.

The above definition reflects the same perspective as that enunciated by the U.S. Public Health Service Subcommittee on Health Manpower Credentialing:

> *Certification:* The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association. (Quoted from "Credentialing Health Manpower," July 1977. U.S. Department of Health, Education, and Welfare, Public Health Service, p. 4. DHEW Pub. No. OS 77-50057.)

A year prior to its adoption, the ANA definition appeared (in slightly simpler form) in the November 15, 1976 issue of *The American Nurse*. Responses that followed were taken into consideration when the definition was finalized. At present, ANA's certification program is ready for the next step: to publicize guidelines indicating how the definition can be implemented. Nurses, therefore, will be apprised of the overall content of the certification program. This program will be responsive to the consumer as well as to the practitioner who seeks certification in an effort to serve the public better.

At its December 1977 meeting, the ANA Board of Directors allocated funds for a two-year plan of certification examinations. It is anticipated that the plan will expand markedly in the future. Nurses will know well in advance when the test corresponding to their specialization in nursing is to be administered. Thus, they can expect to take the examination in ample time and with appropriate preparation. It should also be noted that the ANA Board approved the principle of investigating the feasibility of establishing a separate corporation to provide certification measurement and research services. . . .

Issues

A variety of issues surrounding certification need to be resolved. It must be emphasized from the outset that decisions concerning this entire process rest with the divisions; each division attempts to solve its certification problems in its own way. At the same time, divisional representatives on the Interdivisional Council on Certification recognize that the broad characteristics of the certification program must reflect the mission and the philosophy of the ANA. Much collaborative effort has been expended to strike the proper balance between the uniformity reflecting the goals of the association and the diversity representing the uniqueness of the different areas of nursing practice. By necessity, the process of completing the total certification program has been slow; yet, it has produced growth and professional alignment.

A viable certification program is operating. Also, there is the realization on the part of the divisional certification boards that a constantly changing society requires constant changes and new developments in certification. As they respond to these pressures and make decisions of major impact, certification boards perform a significant role within the ANA and for the profession.

Certification and quality assurance have come to a logical closure. The American Nurses' Association now presents a program of certification, enabling nurses to demonstrate their skills on the highest level—they are qualified to care.

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Chairperson, ANA Interdivisional
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Endorsed by the ANA Interdivisional
Council on Certification
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L. Wilson

report on Licensure and Related Health Personnel Credentialing

June 1971

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Report on Licensure

and Related

Health Personnel Credentialing

June 1971

DHEW Publication No. (HSM) 72-11

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Assistant Secretary for Health
and Scientific Affairs
Washington, D.C. 20201

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

July 28, 1971

To the Congress of the United States

In accordance with the requirements of the new subsection 799A of the Public Health Service Act (Public Law 91-519), I am herewith respectfully submitting to you a report identifying the major issues associated with licensure, certification, and accreditation for practice or employment of health personnel.

To assure implementation of the recommendations in Chapter XI of this report, the continuing cooperation and support of the Members of the Congress are also respectfully requested.

Secretary

Enclosure

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PREFACE

Public Law 91-519, enacted on November 2, 1970, contained an amendment to the Public Health Service Act in the form of a new subsection; i.e., Sec. 799A, which is quoted as follows:

"SEC. 799A. The Secretary shall prepare and submit to the Congress, prior to July 1, 1971, a report identifying the major problems associated with licensure, certification, and other qualifications for practice or employment of health personnel (including group practice of health personnel) together with summaries of the activities (if any) of Federal agencies, professional organizations, or other instrumentalities directed toward the alleviation of such problems and toward maximizing the proper and efficient utilization of health personnel in meeting the health needs of the Nation. Such report shall include specific recommendations by the Secretary for steps to be taken toward the solution of the problems so identified in such report."

ACKNOWLEDGEMENT

This report was prepared by a working group, comprised of a number of representatives of this Department and assisted by other Federal agencies. The cooperation of the professional organizations is also gratefully acknowledged.

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INTRODUCTION

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CREDENTIALING AND THE PUBLIC INTEREST

Better health care is clearly a national priority of the highest order. The achievement of this goal requires more and better trained health-manpower, especially allied health personnel; more responsive and more appropriate health-care facilities; improved financing arrangements for the entire population; and more effective planning to create a health system that will deliver what it promises to all.

Happenstance did not cause health manpower to be placed first on the list of requirements above. Health manpower represents the key element in building a National Health Strategy sufficient to confront and overcome the present, deepening crisis in the United States. At this time, impending changes in the patterns of health-care delivery can be sketched in a general outline. These changes include an increasingly larger ratio of allied health personnel to physicians; increasing numbers of prepaid, group-practice plans; increased public attention on health-care financing plans; more attention to the effective functioning of health-care teams; greater emphasis on care outside acute-care hospitals in the forms of ambulatory, preventive, and health-maintenance care; a shifting of attitudes toward health care as a public utility with appropriate accountability to the public; rapid acceleration in the utilization of continually advancing biomedical knowledge and technology; and a management-systems orientation for health-care delivery. In the context of these expectations, manpower issues become considerably more critical, not less.

The increased Federal funding for the development of health personnel provided over the last few years reflects a national concensus concerning the importance of education, training, and full utilization of this Nation's manpower resources. Understandably, the American taxpayer wants an equitable return on his public investments. Specifically, with regard to health manpower, he expects the removal of all obstacles to substantially increased productivity -- this to be coupled with the maintenance or, in some cases, improvement of the quality of health care provided. Unless there are structural changes in the organization of health care, there is grave danger that those dollars will simply contribute to an inflationary mirage to frustrate an increasingly health-conscious public.

Only a few years ago, issues such as licensing, certification, and accreditation were generally thought to be the concern of only the professional individuals and organizations that were affected by them. The public-policy aspects of these issues were not often perceived by decision-makers, long accustomed to the guild traditions that have characterized attitudes in this

area. Today, these matters are not immune from public criticism; and the responsibility of both public and private leadership is to fuse health-manpower credentialing with the public interest.

It is surprising that the delivery system in this country has functioned as well as it has for so long, when one considers the stresses placed on it not only by new knowledge and technology, but also by escalating health-care demands. Earlier, many of the inherent inefficiencies of the system were absorbed by dedicated people working long hours and, in some cases, for extremely low pay. It is unrealistic to expect these compensatory phenomena to continue indefinitely.

The purpose of this report is to examine the major problems of licensure and related aspects of certification and accreditation. What inefficiencies are they contributing to the present health-care system?

During the past quarter century, this country has experienced a sharp increase in occupational licensing legislation. Twice the number of professions, skilled trades, and even semiskilled jobs are contingent upon a satisfactory demonstration of competence and integrity before a governmental licensing body.

Licensing was originally intended to protect the public from dishonest and incompetent practitioners. Current licensing practices may obtain an additional result; they limit the number of practitioners by imposing unnecessarily difficult requirements as conditions for acquiring a license. Furthermore, licensure qualifications are set, generally, by the professions themselves; and professional control is maintained through boards of examiners composed of or dominated by the professional practitioners. Thus, licensure may mean only that licensed practitioners meet standards set by their own profession; it does not necessarily mean that the State has evaluated the profession's standards and has approved these standards as being valuable to society.

Improvements are needed, as suggested in this report, not only in the public regulation -- licensing -- of health manpower, but also in the private credentialing processes of accreditation and certification. Accreditation procedures, for example, are currently being criticized for allegedly contributing to the perpetuation of the guild system associated with professional education. New forces are facing higher education today; they pose the question of whether or not accreditation can be fused with public accountability.

While the needs of and expectations for credentialing are great; so, too, are the opportunities for responding to these challenges. This appears to be a most favorable period for improved endeavors. Current reasons for this include:

1. Health care is ranked as one of the major concerns of the American people.
2. Students are highly motivated to encourage and support constructive change.
3. Many professional associations are eager to play a leadership role in finding better ways to provide high-quality health care for all Americans.
4. Signs point increasingly to a greater receptivity of national leadership concerning the various aspects of health-personnel credentialing.

To progress amidst the complexities of licensure, certification, and accreditation requires continued dialogue and cooperative action among educators, professional leaders, and government officials at State and national levels. For example, to prevent further fragmentation of health careers, professional organizations should be encouraged to continue coordinating interrelated allied health personnel within career lines. Additional progressive developments that foster good working relationships between categories of health personnel should be supported. These include joint statements and actions by professional organizations that provide guidelines for the education and training of given categories of health personnel as well as attempts to clarify obscure areas of practice acts by recognizing customary practice between professions. A number of professional groups have contributed new and innovative programs in this field that have aided the development of a more rational system of health disciplines and occupations. The Department endorses these efforts and is taking steps to encourage further innovation and experimentation.

At the Department's recent Working Conference on Health Personnel Licensure, discussions confirmed the value of close contact with professional groups. Communications -- before and after the Conference -- with both Conference participants and representatives of other organizations have underscored the merit of cooperative action. The purpose of the Conference was not to solicit formal organizational positions on detailed issues, but to provide representatives of the Department with insight and information, based on the judgment of non-Federal health leaders, as to the directions that should be pursued in the field of credentialing.

The States, too, are taking important action on these matters. Several States have enacted legislation that provides for the functioning of new categories of health practitioners, such as assistants to physicians. Assistance

should be provided to those States requesting it in their efforts to update their health-personnel credentialing regulations. Furthermore, State licensure has been or is being sought by many different health occupations; with additional enactments, it will be increasingly difficult for the States to provide meaningful surveillance over the many licensing statutes on their books. In advocating State changes in health licensure, the full potential impact of such changes within that State must be recognized -- for example, the relationship of changes to the State personnel merit-system.

Two matters that are receiving considerable attention today -- group practice and medical malpractice -- should be briefly mentioned in connection with this report. With regard to group practice, the general rule has been that, while a corporation is for many purposes legally considered to be a person, a corporation cannot be licensed to practice a learned profession. Thus, most prepaid, group practices are forced to contract with physicians for their services. This creates questions in connection with the liability and responsibility for supervision of allied health professionals who may be utilized by the group plan. Additionally, certain group practices operate health-care plans in several States. In many cases, the lack of licensure reciprocity precludes the possibility of transferring trained health professionals throughout their organizational network.

The President, in his recent Health Message, directed that a Commission on Medical Malpractice be established. Its mandate is to undertake an intensive program of research and analysis into this complex problem. The detailed aspects of the relationship between personnel credentialing and malpractice will be studied and reported by March 1, 1972. Two points, however, should be made here:

1. Both malpractice and licensure influence the quality of health care. Medical malpractice actions assess specific cases to determine whether or not care was rendered free from negligence; licensure laws influence the quality of care through the establishment of standards for entry into a specific field of practice.
2. Under the doctrine of *respondeat superior*, the employer is responsible for all negligent acts of persons in his employ, where such acts occurred within the scope of employment. Thus, physician liability for negligent acts of an assistant exists, whether or not the assistant is licensed, as long as the assistant is working under his supervision and control. The question of licensure, however, is relevant in some jurisdictions to the procedural matter of the burden-of-proof regarding negligence.

Although there are no hard data on the economic effect of licensing laws, an analysis of increased hospital costs suggests some effect in salary demands

when there is legislative recognition of health occupations; the health-insurance industry and, in turn, policy holders are also affected. With continued licensing of professions, individual practitioners may become more guild-oriented and may prefer to practice independently of the physician or other health professional. Such a result could lead to separate billings from each of the members on the health team; furthermore, it could create certain problems in administering health-insurance programs. Add to these factors the variations in licensure among the States, and the problems of determining who is eligible for payment become insurmountable.

There are other economic considerations in credentialing that should be examined. The time and monetary burdens to educational institutions must be recognized where licensure and certification requirements result in formal training that is longer than is really needed to acquire appropriate qualifications for health-care occupations.

Despite an awareness of the various ramifications of these serious and complex problems, quick solutions are often endorsed. First, it would be easy to offer the impression that all of the solutions to the health-manpower problems faced by this country are related to licensure, certification, and accreditation. To the contrary, many forces other than these contribute to these issues and will have to be considered in the ultimate solutions. Wages and working conditions, requirements of educational institutions, location and standards of health facilities, and administrative and organizational patterns of providing services are frequently more directly involved in resolving manpower problems than licensure laws and certification procedures. Regulation of personnel, however, does affect each of these problems. Credentialing procedures should affirmatively contribute to manpower solutions; or, at the very least, they should not constitute hurdles to be overcome in the delivery of services.

Secondly, with increased public discussion of these matters, there is a temptation to accept the following types of allegations without critical examination:

1. That licensure and certification have outlived their usefulness as quality-control and consumer-protection measures, inasmuch as self-perpetuating judgments on these matters are being made almost exclusively by vested-interest groups.
2. That these systems have become exclusion-oriented devices for the protection of professional and economic interests of certain groups.
3. That licensure and certification rigidities have severely limited career opportunities for new types of professionals and, thus, have contributed directly to the health-manpower shortage.

Obviously, these are emotion-laden matters; and they must be carefully and objectively examined before action is undertaken. Progress beyond the present situation will require provisions not only for new categories, but also for the full utilization of those that presently exist. Increased endorsement and application of the health-team concept may well lessen the need for new occupational titles to be supported by governmental regulation. Incentives are needed to induce progress and to replace reliance on negative controls.

Health care in the United States will undoubtedly continue to be in a state of flux for some time. Although specific steps are needed for improving the credentialing system, simultaneous and ongoing changes must be recognized and accommodated so that inflexible measures are not adopted prematurely. In the eager quest for reform, this Nation should not be deluded by adopting quick solutions that, ten years hence, may result in nothing better -- or even worse, a further deterioration in health status.

While a concern for the achievement of social goals means that various factors will be considered in making policy that affects health-manpower resources, the overriding element of patient protection must be the all-controlling factor. Public safety cannot be sacrificed for other considerations, regardless of their merit.

It will be impossible to reconcile all of the disagreements on specific points in connection with health-personnel credentialing in the United States. In so broad and dynamic a field as this, such a situation is not only inevitable; it can also be healthy and lead to continuing improvement. Hopefully, this report will have succeeded in addressing itself to all decision-makers at every level in both public and private sectors; if their talents and skills can be brought to bear on these issues, health-care problems will be solved in a manner that their national importance merits.

CHAPTER II

AN OVERVIEW OF HEALTH PERSONNEL CREDENTIALING[1/]

Credentialing of health manpower takes three forms -- accreditation of educational programs, certification of personnel by the profession, and licensure by a government agency. The three aspects are closely interrelated and, at times, the terminology is employed interchangeably. State practice acts, establishing the procedures for licensing, usually contain educational requirements. Professional associations, too, usually require that the applicant satisfy certain educational qualifications. For purposes of clarity, the following definitions are presented:

Accreditation -- The process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined criteria or standards.

Licensure -- The process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected.

Certification or registration -- The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association. Such qualifications may include: (a) graduation from an accredited or approved program; (b) acceptable performance on a qualifying examination or series of examinations; and/or (c) completion of a given amount of work experience.

Interlocking Relationships

Accreditation, licensure, and certification have developed independently of one another to meet pragmatic functional and social needs. Based upon this historic pattern of evolution, the structure of these evaluative systems today interlock with each other.

1. In most cases, the key persons involved in all three procedures simultaneously are bona-fide members of the profession. It is not unusual to find the same individuals serving at once in two capacities; for example, on accrediting teams and on a State licensure board.

[1/] Substantive material in this chapter has been reproduced from two Public Health Service reports: *Accreditation and Certification in Relation to Allied Health Manpower* (NIH Pub. No. 71-192) and *State Licensing of Health Occupations* (PHS Pub. No. 1758).

2. Licensure and certification are dependent upon graduation from prior accredited programs; previously-qualified students are subjected to narrowly-focused, specialized examinations that are primarily related to formalized academic experience. In short, the examinations actually revalidate academic study rather than assess current competency or past experience.
3. The health field, in the past -- relatively speaking -- has been organized so as to avoid dependence upon outside sources of influence. Furthermore, the health professions' claims of specialized knowledge and expertise have minimized outside intervention. Consumers of health services and patients under medical care have, generally, relied upon the health professions' assertions of unquestioned autonomy and authority, due to the inability of the layman to assess the quality of health services.

Counter-balancing these factors, certain other aspects should be considered:

1. The medical system has, in fact, eliminated the abuses prevalent before publication of the Flexner Report;
2. Approaches such as Medicare, MEDEX, and physician-assistants programs are being more widely examined and supported;
3. Biomedical research and scientific knowlege have attained high standards of excellence and have advanced the health status of our population.

As the frontiers of health science and knowledge expand into an increasingly complicated state-of-the-art, there arises an equally vital and increasing need to achieve reforms within the profession and its credentialing system. These reforms should focus upon the need to ventilate the professions' attitudes beyond immediate techniques and technicalities by exposing professionals to broader, outside influences. Thereby, a larger social perspective would be attained, and a larger public responsibility would be voluntarily assumed by the health professions as a whole.

Such responsibility inevitably will be forthcoming; the question is not whether it shall come, but rather in what context and under what format? And the query is whether such responsibility will be accepted, acknowledged and led by the medical professions, or rather, will it be imposed by society upon a reluctant and unwilling professional group?

During recent years, considerable attention has been focused upon the various aspects of health-personnel credentialing. The following sections provide an overview of accreditation, certification, and licensure. (1)

Accreditation of Educational Programs

Accreditation is a form of regulation or control that is exercised over educational institutions and/or programs by external organizations or agencies. It developed in this country as a procedure of voluntary self-regulation by peer groups of educators and members of the respective profession, in contrast to review and regulation of educational institutions as a governmental activity in other countries. The initial focus was on colleges and universities to meet the needs of educators, educational institutions, programs, and professional groups and subgroups within our society; only later, was there concern for the public interest.

The U.S. Office of Education defines accrediting as the process whereby an association or agency grants public recognition to a school, institute, college, university, or specialized program of study having met certain established qualifications of standards as determined through initial and periodic evaluations. Increasingly, accrediting also implies stimulation toward quality-improvement beyond the minimum standards specified by the accrediting body.(2)

The purposes of accreditation as they have evolved in this country are many and varied. Among the functions relating to or using accreditation are the nine listed below:

1. Certifying that an institution has met established standards;
2. Assisting prospective students in identifying acceptable institutions;
3. Assisting institutions in determining the acceptability of transfer credits;
4. Helping to identify institutions and programs for the investment of public and private funds;
5. Protecting institutions against harmful internal and external pressures;
6. Creating goals for self-improvement of weaker programs and stimulating a general raising of standards among educational institutions;
7. Involving the faculty and staff in institutional evaluation and planning;
8. Establishing criteria for professional certification, for licensure, and for upgrading courses offering such preparation; and
9. Providing bases for determining eligibility for Federal assistance.

The accrediting procedure, itself, usually follows a pattern of five basic steps:

1. The accrediting agency, in collaboration with professional groups and educational institutions, establishes standards.

2. The institution or program desiring accreditation prepares a self-evaluation study that provides a framework for measuring its performance against the standards established by the accrediting agency.
3. A team selected by the accrediting agency visits the institution or program to determine first-hand if the applicant meets the established standards.
4. Upon being satisfied through the information obtained from the self-evaluation and the site visit that the applicant meets its standards, the accrediting agency lists the institution or program in an official publication with other similarly accredited institutions or programs.
5. The accrediting agency periodically re-evaluates the institutions or programs that it lists to ascertain that the standards are being met.

In general, there are two types of accreditation: institutional and specialized. Institutional accreditation applies to the total institution and indicates that the institution as a whole is achieving its own validated and specified objectives in a satisfactory manner. Specialized program accreditation is aimed at protecting the public against professional incompetence. Whereas the eligibility criteria, basic policies, and levels of expectation are similar among institutional accrediting associations, the criteria for accreditation, definitions of eligibility, and operating procedures of the specialized program accrediting agencies vary considerably.

Due to the differing emphases of the two types of accreditation, accreditation of the institution as a whole by the institutional accrediting associations should not be interpreted as being equivalent to specialized accreditation of each of the several parts or programs of an institution. Institutional accreditation does not validate a specialized program in the same manner and to the same extent as specialized accreditation. For example, institutional accreditation of a college or university does not imply that each specific curriculum and/or department, such as dental hygiene or physical therapy, is accredited. However, specialized accreditation usually requires that the program be housed in an institution that has been accredited.

U.S. Office of Education. Unlike most other countries, the United States has no ministry of education or other centralized authority that exercises control over educational institutions. The States, and in many cases, counties and cities, assume varying degrees of control but permit institutions of higher education to operate with considerably autonomy. As a consequence, institutions vary widely in the character and quality of their programs. Private (nongovernmental) educational associations of regional or national scope have established criteria to evaluate institutions or programs, with the intent of determining whether or not they are operating at basic levels of quality.

For purposes of determining eligibility for certain Federal programs of aid to education, the U.S. Commissioner of Education is required by law to publish a list of nationally recognized accrediting agencies and associations that he determines to be reliable authority as to the quality of training offered by educational institutions and programs.(2) Most institutions thus become eligible for Federal funds by way of holding accredited or preaccredited status with one of the accrediting bodies recognized by the Commissioner. In some legislation, especially that intended to help new institutions, provision is made for special qualifying steps that may be taken as alternatives to the normal accreditation process, such as evidence of working toward accredited status.

The Commissioner's list of nationally recognized accrediting agencies and associations includes institutional and specialized associations having responsibility for accrediting post-secondary institutions and programs. Inclusion of an institution on the approved list, which is revised periodically, of nationally recognized accrediting agencies and associations is generally accepted as the most significant indication of institutional quality.

National Commission on Accrediting. The National Commission on Accrediting was established in 1949 by colleges and universities for the primary purpose of serving as a coordinating agency for accreditation activities in higher education.(3, 4) An independent educational agency with a membership of more than 1,425 colleges and universities, the National Commission has worked as the agent for its members in granting recognition of qualified accrediting agencies, helping to improve accrediting standards and practices, fostering increased cooperation among accrediting agencies, and recommending action concerning accreditation to its member institutions. The National Commission does not itself perform an accrediting function, but recognizes specialized agencies to grant program accreditation in 37 fields and relies upon the seven college commissions of the regional associations to grant institutional accreditation.

The National Commission on Accrediting has recognized the Council on Medical Education of the American Medical Association for the accreditation of allied medical programs for the training of medical record librarians, medical technologists, occupational therapists, and physical therapists. Similar recognition has been given to the Council on Dental Education of the American Dental Association for the accreditation of allied dental programs for the training of dental hygienists, dental assistants, and dental laboratory technicians.

AMA Council on Medical Education. Organized medicine has taken leadership in the approval of medically-related educational programs. The Council on Medical Education of the American Medical Association is the focal

APPENDIX B

THE PHYSICIAN ASSISTANT

Introduction

In the past few years, there has been a growing interest in a broad array of health personnel who perform certain substantive medical care tasks that were formerly limited to physicians or other health practitioners. This type of personnel is generally referred to as the physician assistant. President Nixon, in his Health Message to the Congress, on February 18, 1971, stated:

> One of the most promising ways to expand the supply of medical care and to reduce its costs is through a greater use of allied health personnel, especially those who work as physician's and dentist's assistants, nurse pediatric practitioners and nurse midwives. Such persons are trained to perform tasks which must otherwise be performed by doctors themselves, even though they do not require the skills of a doctor. Such assistance frees a physician to focus his skills where they are most needed and often allows him to treat many additional patients. (144)

The current interest in physician assistants is related to a number of important developments affecting this Nation's health policy. These include: (a) the increasing demands for health services; (b) the scientific and technological advances facilitating the more effective delivery of health services; (c) the recognition of health as a right of all citizens regardless of social and economic status; (d) the shortage and maldistribution of physicians to render the health care that is needed; (e) the rapid rise in the costs of medical care; and (f) the evidence based on demonstrations, particularly by medical personnel in the armed forces, that certain health services can be provided adequately and safely by persons with substantially less training than the physician. Therefore, the development of the physician assistant as a new mid-level practitioner is viewed in some quarters as a principal means of bringing about greater access to health care in this country.

Perhaps the oldest type of physician assistant functioning today is the Russian "feldsher," an extension of a profession introduced into Russia in the 1700's. Feldshers are members of a group of personnel whom the Soviets call "medical workers" and whose responsibilities are somewhere between those of physicians and auxiliary health-personnel. The feldsher's status is high, relative to others in this group, which includes nurses, midwives, pharmacists, and laboratory technicians. In urban areas, the feldsher works as an assistant to the physician -- usually under close supervision by the physician -- and generally performs technical duties. In rural areas, the feldsher has a primary responsibility for preventive medicine and environmental control, but often performs a primary-care role.

In a number of developing nations, a second form of contemporary physician assistant is the "assistant medical officer," a medical auxiliary who functions as a physician. The assistant medical officer's practice often resembles that of the general practitioner in this country. He works closely with other auxiliaries in the field; i.e., midwives and sanitarians, whom he supervises with varying degrees of competence.

Duties and Functions of Physician Assistants

While the title "physician assistant" is beyond doubt the term most generally applied to this new type of personnel, other nomenclature currently in use includes the "physician's associate," the "medical specialty assistant," and "MEDEX." In addition, there are numerous other designations for health personnel with expanded roles. Moreover, there is considerable difference of opinion about the duties, functions, and responsibilities that can, and should, be delegated to physician assistants. While no definitions or approaches are generally accepted at this time, there is considerable interest in preserving the necessary latitude for modification based on experience with physician assistants.

There appears to be growing interest in a uniform terminology for specified categories of physician assistants. Such uniformity would allow for lateral mobility between medical specialties and types of practice. A recent report by the National Academy of Sciences (NAS) delineates three types of physician assistants "primarily by the nature of the service each is best equipped to render by virtue of the depth and breadth of their medical knowledge and experience:

The Type A assistant. This type 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 or 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 physician. 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. While not equipped with general knowledge and skills relative to the whole range of medical care, this type 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 a Type A assistant and perhaps 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. An example of this type of assistant might be one who is highly skilled in the physician's functions associated with a renal dialysis unit and who is capable of performing these functions as required.

The Type C assistant. This assistant 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 a 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. This type of assistant would be to medicine what the practical nurse is to nursing. (145)

The NAS report further notes that while the Type A assistants are new to the American scene, the Types B and C assistants have been functioning in this country, in one form or another, for some time.

Organizational Interest in Physician Assistants

Many medical specialties have considered establishing a physician assistant category; and several have already done so, including orthopedic surgery, pediatrics, obstetrics, and urology. Pediatrics and orthopedic surgery have provided definitions of job duties and training-program requirements. In the case of pediatrics and obstetrics, agreement between the nursing and medical professions on the roles and preparation of pediatric nurse-practitioners and nurse midwives has been achieved. Other types of programs include the physician assistant's role in geriatrics, certain chronic diseases, anesthesiology, surgery, ophthamology, radiology, emergency care, coronary care, and nuclear medicine.

The attitudes of physicians (146) concerning the delegation of elements of their practice to trained assistants under supervision indicates a high degree of acceptance of the concept of the physician assistant and a willingness to share elements of practice that have been traditionally the prerogative of the physician. In a survey of 3,425 internists active in patient care, the American Society of Internal Medicine found that internists believed many elements of their practice could and should be delegated to an allied health worker. (147) These included recording elements of the history (60 percent willing to delegate), home visits (65 percent), patient instruction (70 percent), nursing-home visits (43 percent), and performance of Pap smears (34 percent). The American Academy of Pediatrics, in a survey of 5,799 pediatricians, found that over 70 percent favored delegation of such activities as recording elements of the history and counseling on child care, feeding, and development. (148)

More than half felt that an allied health worker should make home visits in follow-up of cases of acute illness and chronic disease; and this assistant should provide medical advice on minor medical matters. A smaller, but significant, number favored delegating well-child examinations (25 percent); sick-child examinations (20 percent); and newborn visits to maternity hospitals (32 percent).

In both of these studies, as well as that performed in the field of obstetrics, (149) there is a wide gulf between what the physician feels he could and should delegate and what he actually does. More than half the pediatricians feel that lack of trained workers is a very serious obstacle to delegation of tasks. The internists indicated that they were equally willing to have patient-care tasks, traditionally restricted to the physician, carried out by a professional nurse or a physician assistant; there was a slight preference for the physician assistant in physical examination and patient follow-up and for the nurse in therapeutic activities. Despite the professed willingness to entrust such activities to the nurse, such delegation is rarely done in the 40 percent of internists' offices that have a professional nurse.

Coye and Hansen (150) queried 1,345 Wisconsin physicians about their attitudes toward the physician assistant and found a high percentage who indicated a need for such an individual -- 55 percent of family practitioners, 66 percent of pediatricians, 64 percent of internists -- and willingness to use them in their practices -- 42 percent of family practitioners; 41 percent of pediatricians; and 44 percent of internists. Forty-one percent of pediatricians indicated that they would hire a full-time allied health worker (type not specified), if available.

Acceptance of the physician assistant by both patients and physicians is reported to be good in studies conducted at Duke University; least acceptance was demonstrated by patients in the lowest-income and educational levels. (151) Ninety-four percent of parents expressed satisfaction with the combined care provided jointly by a pediatrician and a pediatric nurse-practitioner; 57 percent found joint care better than that received from a physician alone. (152)

Current Training Programs

At present, there are about 80 programs in various stages of development involving the training or use of physician assistants in addition to about 50 programs that extend nursing roles. (153) A number of additional programs are in the early stages of planning. The training period of most existing programs ranges from four months to three years. The short-term programs enroll highly trained, experienced students and give them a new orientation,

some didactic training, and new clinical skills. The short training-period means that the corpsmen entering MEDEX or the nurses entering a nurse-practitioner program must be, initially, highly qualified. The longer programs accept applicants with much less training (two years of premedical college credit or some practical experience as a corpsman or licensed practical nurse) and provide generally one year of didactics, one year of clinical training, and one year of internship -- in consecutive order.

Several training programs are described below to furnish some indication of the range of programs related to physician assistants:

Duke University: Physician Assistant Program. (154) Applicants should have a high-school education including some science and three years of medical experience such as that of medical corpsman or licensed practical nurse. The course comprises nine months of didactic work followed by fifteen months of clinical practice. The student is trained to assist a specific physician and to carry out some of his more routine tasks as requested. He may be trained as either a generalist or a specialist. The first class graduated in 1970.

University of Colorado: Child Health Associate. (155) Applicants who must have two years of undergraduate work at an approved college take a two-year course with the first year devoted to the basic sciences; and the second, to clinical experience. After a baccalaureate in science is awarded, graduates must serve a year of internship. The associate is trained to provide nearly all of the care of well children and to treat most mild diseases. Within established limits, the associate is qualified to diagnose, counsel, and prescribe. The first class will graduate in 1971.

University of Washington: MEDEX. (156) The program accepts only highly skilled, independent duty, ex-medical corpsmen for a three-month course of intensive training that is followed by a one-year internship with the future employer. Employers are rural physicians who have agreed in advance to hire the MEDEX at $8,000 to $12,000 per year after the internship. During the 15-month program, the student is paid $500 a month. The MEDEX is allowed to perform all physician functions, except those requiring a very high degree of skill and judgment. The first class graduated in August 1970. (157)

Bowman Gray University: Physician Assistant. (158) Applicants must have either two years of approved premedical college credit or corpsman experience. The 24-month program includes one year of didactic training and one of clinical experience. The first six months are part of a core curriculum, common to other allied health students. The program began in September 1970.

University of Colorado: Pediatric Nurse Practitioner. (159) Applicants must have a B.S. degree in nursing. The course consists of four months of intensive theory and practice in pediatrics with emphasis on nursing management of children and the nurse's role in community settings. Upon graduation, some of the pediatric nurse practitioners (PNP) have operated "solo" in field stations and in low-income, rural areas where they give total care to both well children and to approximately half the ill children; the remaining ill children are referred to a conventional clinic. Other PNP's work in private offices with pediatricians where they provide almost complete well-care and participate in the care of the sick child. The first class graduated in April 1970.

Massachusetts General Hospital: Pediatric Nurse Practitioner. (160) Applicants must be registered nurses currently working in either a private office or public clinic with an employer interested in cooperating with the program. The course consists of didactic work one and one-half days a week for 16 weeks, while the applicant simultaneously receives on-the-job practice in the new techniques. In addition to assisting the physician, the PNP will assume most of the responsibility for well-child care, as well as make house and hospital calls. The first class graduated in June 1970.

The Federal Government is currently sponsoring many of the existing physician assistant projects. The Department has assumed a major share of this support in the following agencies: (a) HSMHA -- physician assistant projects are primarily located in the National Center for Health Services Research and Development, but other programs involved in some training include Regional Medical Program Services, Indian Health Service, and Federal Health Programs Service; (b) NIH -- Bureau of Health Manpower Education; and (c) the Office of Education. Additional funding is provided by the Office of Economic Opportunity and the Manpower Administration of the Department of Labor.

Legal Issues

The legal issues regarding physician assistants are complex and have evoked much controversy. Of major concern are problems such as liability, malpractice, and the legality of delegating tasks to nonphysicians. Inasmuch as medical practice acts in all States prohibit the practice of medicine without a license, many tasks currently being considered for physician assistants -- without amendments to medical practice acts -- would constitute the illegal practice of medicine. The results of a series of conferences on the legal implications of the Duke physician assistant program are summarized in the report of the Conference on Legislative Proposals for Physician's Assistants. (161) Conference delegates agreed that State medical practice acts should be amended rather than replaced through the enactment of new laws for physician assistants. This consensus was predicated, in large measure, on the view that

licensure laws on physician assistants would limit change and introduce rigidity into a system that is changing rapidly. Several States, have amended the medical practice acts to give the physician the widest possible latitude in delegating tasks to an assistant. Typical of these is the Oklahoma statute:

> (N)othing in this article shall be so construed as to prohibit ... service rendered by a physician's trained assistant, a registered nurse, or a licensed practical nurse if such service be rendered under the direct supervision and control of a licensed physician. (162)

One proposal would modify this wording so that the "act, task, or function is performed in accordance with such rules and regulations as may be promulgated by the Board of Medical Examiners." (163) A more strict proposal would have the Board of Medical Examiners specify what training is necessary for specified roles and tasks. (164) A third proposal would have the Board of Medical Examiners consider a petition by an individual physician or institution that specifies the training of a particular employee and the tasks he will perform. (165) These proposals differ as to the amount of responsibility given to the physician and as to who shall judge a candidate's qualifications or performance.

Several professional organizations support proposals that would give wide scope to the physician and allow for "growth in the delegation of duties to ancillary health workers." (166) To date, State legislatures have taken a wide range of approaches. As mentioned above, several States have adopted delegatory authorizations. Colorado has enacted a highly detailed licensure law for "child-health associates," defining and regulating their activities comprehensively. California recently enacted a law that requires the physician to petition the Board of Medical Examiners to certify a particular applicant to perform specified duties. An additional 20 or more States are considering a variety of legislative proposals relating to the physician assistant.

Conclusion

Rising needs and expectations for medical care require expanding numbers and expanded roles of existing health personnel as well as the development of new types of health manpower. The need to increase health services is handicapped by problems associated with the preparation of more physicians, but the further development of appropriate physician assistants may assist in meeting the future health needs of the population in a more efficient way.

The development of new types of health practitioners will undoubtedly engender problems of professional status and competition, professional and public acceptance, methods of training and utilization, remuneration, and legality. Notwithstanding these problems, the physician assistant as a manpower resource may provide new avenues of access to health services that cannot be provided under present manpower supply, utilization, and cost arrangements.