THE LICENSURE OF THE PHYSICIAN ASSISTANT: LEGAL AND POLICY IMPLICATIONS

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THESIS ABSTRACT

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Submitted to the Department of Urban Studies and Planning on June 11, 1973 in partial fulfillment of the requirements for the degree of Master of Urban Studies and Planning.

This thesis is an examination of the legal and policy problems raised by the current attempt to license a new category of health personnel, the physician assistant. The introduction of the physician assistant is of interest and importance because of the need for more and more efficiently organized medical services. The theory is that the physician assistant would perform some of the tasks now done by the physician and would provide services not provided now such as preventive medicine and community health programs. The assistant could be particularly useful in the neighborhood health center in urban ghetto communities and rural America.

Educational programs designed to train the physician assistant are springing up all over the country and it would appear that the current mood is toward some acceptance of this kind of health personnel. At this time, it is necessary to consider the alternative methods available to license this new group. Various states, e.g., Oklahoma, Colorado and California, have already enacted enabling legislation and others, e.g., Massachusetts, are in the throes of making a decision about appropriate legislation. The alternatives available are manifold and each one offers advantages and disadvantages.

This thesis examines the various proposals with an eye toward the legal and policy problems raised by each. Especial attention is given to the proposed Massachusetts legislation because it is both close to home and a reaction to the successes and failures encountered in other jurisdictions. If the Massachusetts proposal is adopted, it would be very instructive to watch "the machine in action." Such data is currently not available.

After the above examination of implications has been made, the thesis analyzes the tradeoffs contained within any one choice in order to select one of the sounder solutions to the current problem.

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INTRODUCTION

In enacting the Social Security Amendments of 1972,[1] Congress officially recognized the existence of a new category of health personnel loosely referred to as the physician assistant. It did so by authorizing the Secretary of the Department of Health, Education and Welfare to study, either directly or through grants to public or private agencies, the appropriate place for the physician assistant in the health care programs established under the Social Security Act.[2] It appears very likely from the preface to this section of the Act, that the Congressional concern behind the amendment was a more efficient use of medical personnel and the attendant reduction in cost for the federal government in the maintenance of its health care program.[3]

The decision to institute study programs is certainly innocuous in itself but the specific provisions of this study grant contain the policy problems which are inherent within the introduction of the physician assistant. The first of these is the definitional one: who is to be included in the new category of physician assistant? In classifying the group to be known as "physician assistant", the statute includes the nurse practitioner. There is much debate in medical circles about whether the nurse is to be considered a part of this new group or whether the physician assistant category is to be made up of a wholly new input into the medical and hospital hierarchy.[4]

The federal statute also requires that the physician assistant be "legally authorized to perform" by the state in which such

services are to be rendered. The question raised by this provision is an extremely problematic and crucial one: are the states to be wholly responsible for the licensure of the physician assistant or will the federal government choose to become more actively involved in this function? The answer to this question includes considerations of constitutional as well as political dimensions.[5] In terms of sheer constitutional power there appear to be no insurmountable reasons why the federal government could not act as the licensure agency. Its choice not to perform such a function is reflective of a particular attitude toward the delicate balance between state and federal power which lies at the root of the republican form of government. And yet, there are those who would argue that the refusal of the federal government to play a very active role in this area will mean the ultimate failure of attempts to introduce the physician assistant in an effective and rational way.[6]

Probably the most significant provision of the federal legislation in terms of the problems connected with the introduction of the physician assistant is the requirement that the physician be held fully, legally and ethically, responsible for any work done by the assistant. This liability has been the traditional response of the courts.[7] To hold the master responsible for all the acts of his servant has been the chief method for insuring that quality was maintained when tasks were delegated and that there would be a good chance to collect for negligence actions.[8] But such strict vicarious liability and the potential lawsuits and damages it portends are markedly inhibiting for the

physician. The problem faced by the policy planner concerned with the role of the physician assistant is whether there is any other way of maintaining quality control without such inhibiting effects.[9] Also involved in this question is the development of a sense of professional responsibility and group-image for the physician assistants. This is certainly an important consideration in the incipient years of any professional group and the relationship between the physician and the assistant will be a crucial factor.

The 1972 amendments to the Social Security Act raised all of the above legal/policy issues involved in the introduction of the physician assistant. This thesis is an exploration of those questions based largely upon the experience of several jurisdictions which have enacted legislation concerned with the physician assistant. In order to understand the need for a new category of trained medical personnel, it is necessary to have some background of the current medical manpower situation and the changing needs of the American community. This is contained in Section I. Section II looks ahead to the goals of an improved health care system and considers the alternatives currently before us to meet those goals. A new category of personnel, loosely defined as the physician assistant, is one of those alternatives. As will be noted, this is not the only choice and may not be the wisest one, but it seems to be the one with the greatest potential for success at the present time. This thesis is an examination of only that choice. The final bit of background contained in Section II is an analysis of the various policy and legal constraints which

must be overcome before the physician assistant can be integrated into the health care structure.

With the above as background, the remainder of the thesis concerns itself with the various methods available to license the physician assistant and the legal and policy implications which emerge from each of them. Section III describes the various routes and Section IV evaluates each of the schemes in the light of five problems: educational requirements, scope of care of the physician assistant, the liability of the physician, the standard of care to be applied to the physician assistant in assessing negligence and the administrative or implementation problem. In this latter section, the California experience is used as a case study.

The introduction of a new class of medical personnel is bound to have consequences other than fulfillment of the positive goals outlined in Section II. Section V is an attempt to outline some of the problems which seem likely to emerge. Particular emphasis is placed on conflict which may develop between the nurse and the physician assistant. These "by-products" cannot be completely avoided but it would be helpful if planners and legislators could be made aware of these problems before they emerge full-blown.

In the Conclusion, Section VI, I have attempted to bring together the kinds of legal and policy constraints which exist and to weigh the various alternatives against these constraints. The basic question being raised is: Is the option so promising and viable as to warrant the steps necessary to overcome the con-

straints that exist? Based on this analysis, I have chosen one of the alternatives which seems most promising to me at this time. It should be noted, however, that at this point in time, first-hand experience in this area is sorely lacking. In this regard it will be very instructive to observe closely the system as it will operate in Massachusetts if the legislature does enact the "physician assistant credentialling proposal" it is currently considering. If that decision is positive, the experience in this jurisdiction will be an invaluable teacher for those concerned with the development of a more efficient and accessible health care deliver system.

I. MANPOWER STRUCTURE AND THE CHANGING HEALTH CARE DELIVERY SYSTEM

Ineffective delivery of health services is a critical national problem. The visibility of the problem has been made manifest through 1) ever rising costs of medical care; 2) continued fragmentation of services; and 3) increasing shortage of manpower in the health field. The latter problem has generally been interpreted to mean the shortage of licensed physicians because this group is the key participant in the health care structure as it is currently established.

It is necessary to examine the need for physicians in the light of changing health care needs of the country. These changes are the function of shifting demographic and socio-economic needs and "rising expectations" engendered by federal participation in health insurance schemes and the perception of health care as a right rather than a privilege. It is not an increase in the number of practitioners alone which may be appropriate to meet these changed needs.

A. Supply of Licensed Manpower: The Physician Shortage

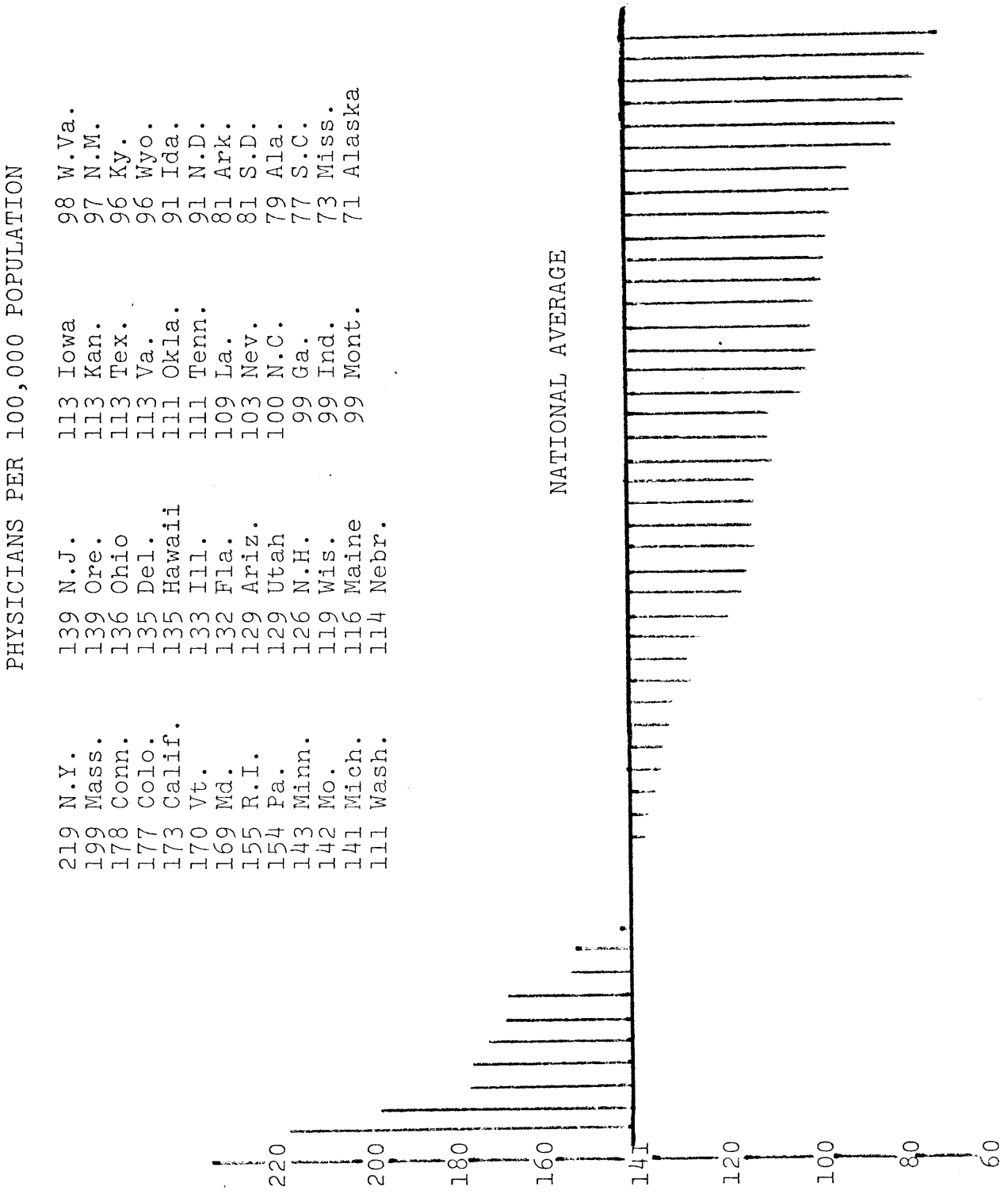
The aggregate measures of health care resources in the very recent past indicate that the supply of physicians has been increasing faster than the growth in population. Between 1950 and 1966, the supply of physicians increased by 34 per cent against a 29 per cent growth in population.[10] The increase between 1966 and 1970 was even more striking. During that time the supply of active physicians grew at twice the population rate, yielding a change in ratios of physicians to population

from 141 per 100,000 persons in 1967 to 155 per 100,000 persons in 1970.[11]

Such aggregate measures of health care resources mask crucial differences which belie the soundness of the manpower supply. There are large geographic variations in an interstate comparison as well as significant disparities among urban, suburban and rural communities. Among the states, the northeastern section fares the best with New York, Massachusetts and Connecticut in the forefront. (See chart on page 11) The southern and far western states have the lowest ratio of physicians to population. Those states with large metropolitan areas have a consistently higher physician to population ratio than those which are more heavily rural.

Another striking disparity is the supply of physicians in cities, particularly the ghettos, as compared with the suburbs of those same cities. In Boston, for example, a study done of Boston and Brookline indicates that the supply of physicians' services has dropped much more radically in the ghetto areas of central Boston than in a suburb like Brookline.[12]

In large part, the great disparities in physician to population ratio track the income differences in communities. In nine out of ten Appalachian states, there are substantially fewer physicians in relation to population in the least wealthy (and generally rural) counties than there are in the wealthier counties.[13] Poorer communities are unable to attract physicians to practice there. Without adequate physicians' services, the hospital facilities in these areas are unused or under-utilized.



RATIO OF PHYSICIANS TO POPULATION, INTERSTATE COMPARISONS

REPRINTED FROM "TOWARDS A COMPREHENSIVE HEALTH POLICY FOR THE 1970'S", U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, GOVT. PRINTING OFFICE, MAY 1971, p.12.

While data showing a higher physician to population ratio existing in urban areas than in rural areas and in high income areas than in low income areas are commonplace, these findings have been challenged on two grounds. First, the physician to population ratio is a meaningless measure of supply. Second, there are few people in this country (one-sixth of one per cent) who are not within twenty-five miles of a physician.[14] In spite of these two counterweights, however, the fact remains that the population of low income areas have less access to and contact with physicians.[15]

An additional problem in the supply of health care services is the change in the physician's role from primary care to specialty practice. Primary care physicians -- general practitioners, pediatricians, and internists -- can handle most of the illnesses and other health care problems with which the population is afflicted. They are generally more concerned about a patient as a whole organism and can render more comprehensive services than their more specialized counterparts. Yet the relative ratio of primary care physicians to population has been steadily declining over the past forty years. The shift to specialization has been rapid. In 1931, roughly 117,000 physicians out of 156,000 were primary care physicians or 75 per cent of the total. In 1950, only 36 per cent of physicians in private practice limited their practice to a specialty. In 1967, there were roughly 115,000 primary care physicians out of 303,000 physicians, or 39 per cent.[16] In spite of the recent popularity of such "generalized" specialties as family medicine and community medicine,

it is unlikely that the trend has turned. This shift from generalist to specialist has contributed to the difficulties that various parts of the country have had in attracting physicians and thus also to the wide disparities that are evident in the physician-population ratio as between rural and metropolitan counties and among the various states.

The final picture emerging from the supply data is that of a specialized, hospital-based[17] physician supply which is concentrated in more well-to-do urban and suburban areas of the nation.

B. Changing Demand in the Health Care Delivery System

The level of supply of services is significant only insofar as it reflects a more telling supply/demand relationship. There is much evidence that there has been a recent marked increase in per capita demand for medical services.[18] This is due to a variety of demographic and socio-economic changes as well as changes in financing mechanisms and public attitude.

1. Demographic and socio-economic changes

The greatest impact on demand is likely to arise out of growth in the size of the population and in income. According to the noted medical economist, Rashi Fein, the former can be expected to increase demand by 12 to 15 per cent by 1975. Income growth will add another 7 per cent to demand. Changes in the proportion of persons with various other characteristics (age, sex, location, color, education) will contribute an additional 2.5 per cent. When the impact of Medicare and Medicaid are added in, the total demand for physician visits can be expected to grow

by perhaps 22 to 26 per cent by 1975 and by 35 to 40 per cent by 1980.[19] This quantitative projection assumes that individuals with given characteristics will, in the future, visit physicians as often as persons with those same characteristics visited physicians in 1964.

2. Federal government participation

The federal government, through a variety of federal and federal/state programs, has opened access to health care services. These programs have increased demand for services because they have provided means for those who, heretofore, could not afford health care.

The first major foray of the federal government into the health insurance field was the Medicare program.[20] Unlike the subsequent Medicaid program, which was designed to function as a partnership between the federal and participating state governments, Medicare is a purely federal plan.[21] It was enacted in 1965 to serve as an insurance program for basic protection against the cost of medical care for those over 65 years of age, with the federal government acting as insurer.[22] The Medicare program was intended not simply as a means of paying medical bills, but also as a way of placing medical care for the aged into the class of "deserved" goods much the same way as Social Security, retirement pay, and the Blue Cross refund are regarded as deserved compensations rather than doles.

The Medicare program has worked very effectively to make medical care available for more than 95 per cent of the elderly.[23] Since the Medicare program is not a welfare program but rather an

insurance program, the elderly are required to pay premiums in order to be covered. There is an interplay of Medicaid and Medicare so that those elderly covered by Medicaid, i.e., needy elderly, have their Medicare premiums paid for by the Medicaid welfare program.[24] As a result of this interface, even the elderly on welfare who are not financially able to pay premiums are included in the Medicare coverage plan.

The Medicaid program,[25] a health program derived from the earlier Kerr-Mills program,[26] was an attempt to provide essential health care services for those under 65 who are unable to meet the cost of health care. The Congressional debates preceding the enactment of the program indicate the concern for providing medical services as a right.[27] The new concept here was that Medicaid would provide mainstream medicine for the needy; they were to be liberated from bondage to a particular doctor, or pharmacy, or to a charity hospital which was either owned by the state or operated under a charity contract with the state. The debates preceding the 1967 "freedom of choice" amendment emphasize the delivery of medical services as a right without the stigma of charity care.[28] Whether or not the Medicaid program has effected sweeping changes in gestalt which would make medical care a right rather than a privilege need not be discussed here. The point to be noted is that there has been an increased demand for medical services as a result of the enactment of the Medicaid program.

The National Health Insurance schemes foreshadow an even greater increase in the demand for medical services. Three of the

current proposals, the Kennedy Bill, the Nixon Bill and the McIntyre Bill, talk in terms of opening up access to the health care industry. The Kennedy proposal uses the broadest language by setting as its purpose the creation of "a national system of health security benefits which, through national health insurance, will make comprehensive health services available to all residents of the United States."[29] The language of the Nixon bill is less sweeping because it sets out to perform a much more limited task. Nevertheless, the provision of basic health insurance for employees by employers[30] would serve to secure more health care for Americans. The McIntyre plan sets as its first objective the increase of supply and improvement of distribution of health manpower.[31]

3. Recognition of health care as a "right" rather than a "privilege"

The activity of the federal government in such programs as Medicaid and Medicare, as well as the lively interest in some form of national health insurance scheme, attest to some change in attitude towards the need for readily available medical services. As indicated above, both the existing federal schemes were enacted to broaden the availability of medical care. The impact of this has been felt in the nation's poverty areas.

The courts have also responded positively in enforcing a broader availability of health care service. In Euresti v. Stenner,[32] the Court of Appeals of the Tenth Circuit took a major step towards the holding that the federal involvement in the medical care field does make for certain fundamental changes in health care delivery. The background for the case is the Hill-

Burton Act under which the federal government gave funds to the states to aid in the construction of hospital facilities.[33] The federal government had dispensed $1.6 million to the state of Colorado in order to help that state provide adequate hospital, clinic and similar services to its people.

In 1970, the plaintiffs brought a class action alleging that the hospitals' receipt of the federal funds meant that there now had to be some rendering of medical services to the state's indigent. The district court held, however, that there was no contractual relationship between the United States and the hospitals and, therefore, the indigents had no right to enforce in the federal court.[34]

The court of appeals took a wholly different view of the situation. It held that Congress had intended to benefit indigent citizens by enacting the Hill-Burton Act and dispensing funds to the states. The court said:

> "Thus the legislative history and the expressed purposes of Congress indicate that the Act was passed to ensure that the indigent would be supplied sufficient hospital services when needed. . . In receiving federal funds, appellees obligated themselves to dispense a reasonable amount of free hospital services to those unable to pay."[35]

The plaintiff-appellants were deemed to have standing to sue to enforce the claim against the state.

Euresti is significant because it so forcefully holds that the federal government involvement in this area was specifically designed to give indigent individuals a right to medical care which they could then go into federal court to enforce. The case does not determine exactly what level of health care is

required, but it does set the stage for further developments.

There has been, and there will continue to be, an increase in the demand for health care services. In addition to an increase in demand for services, there has also been an emphasis placed on the need to provide those services in a dignified and non-humiliating way. As long as the shortage of physicians continues, it is unlikely that there will be resources available to provide more health care services in such a fashion. The existing system does not have the resources and flexibility available to permit this change. And yet, public financing has served only to reinforce the existing system. In order for Medicare to be passed by Congress, there had to be included a specific prohibition of interference in the practice of medicine or the manner in which medical services are provided.[36] Existing modes of delivery have been continued and this has meant an unrestrained use of high cost facilities and procedures.[37]

Any discussion of manpower needs which focuses on physician-population ratios runs the risk of accentuating sheer numbers and losing sight of other crucial goals of an improved health care structure. The next section is an attempt to articulate those goals in order to put the need for the physician assistant in its proper perspective.

II. PLANNING FOR THE FUTURE

A. Goals of an Improved Health Care System

In the last section there was discussion of the demand/supply problems related to licensed physicians. Certainly absolute numbers and absolute need are important variables in the picture. However, it is important not to get caught in sheer numbers and to consider the policy goals we would want served by improving the health care system -- policy goals which may not be met by just increasing the number of licensed physicians. Many of the policy goals will come directly out of the need for more medical services; others will derive from other social policy areas such as civil rights, manpower mobility and an efficient allocation of the national resources.

The first goal is an increase in the amount of medical services. But "medical services" is a term that conjures up a variety of images: the physician involved in demanding surgery; the giving of a tetanus shot; the care of a well baby; instructions on proper nutrition for children. It may be preventive, diagnostic, therapeutic or rehabilitative in nature. So too, the reasons for seeking medical care may be many. They may range from the customary and routine to the need for acute, emergency care. Different needs and different types of people, and it is not at all clear that physician care is required for all.

Any discussion of physician/population ratios runs the risk of focusing only on numbers and neglecting the need for consideration of a more effecient use of medical personnel through

a more rational allocation of resources. In the examples of health care problems listed above, just a few of the myriad, it is obvious that not just one kind of trained individual can serve all those needs, or should serve all those needs. Efficiency and the efficient use of existing personnel is an important policy goal which should not be brushed aside in the craze for more. A greater division of labor and a reassignment of duties and responsibilities of the various members of the health team would increase productivity and would thus add to the total supply of physicians' services. Maximum productivity and optimal use of all members of the health care "team" are goals to be sought after.

In addition to the desired increase in medical services and more efficient utilization -- a bigger pie -- there are important distributional problems -- ways of cutting that pie. As has been noted earlier, rural and poor urban areas tend to be less-well served by the physician population. Generally, this phenomenon has tended to hurt the poor. The demand for medical care services has also been changed both quantitatively and qualitatively by the introduction of Medicaid and Medicare. These programs have caused an increase in low-income demand which, to some extent, presents different needs to the health care industry. The low-income community of the urban ghetto has greater health needs because of environmental circumstances.[38] In addition to dramatic health care problems such as lead paint poisoning and sickle-cell anemia, there are the insidious long-term results of atmospheric pollution and inadequate nutrition. The problems

of access to health care facilities are also more pressing for the low-income population. It is essential that health care facilities for this group be conveniently accessible via public transportation because of the lack of automobiles. In order to be effective, facilities for a low-income population must also be available after working hours rather than the more usual nine-to-five schedule.

It is also likely that a special effort must be made to make the facilities accessible in crucial psychological ways. Low-income people tend to have more trouble facing the large, impersonal hospital. While it is probably true that some of those who have been forced to wait for a long time before being seen by doctors in emergency rooms have built up a wall of stoicism about the situation, the long delays may act as a deterrent to others who need professional services. Language barriers may also make essential communication well-nigh impossible.

In order for health care facilities to be more generally accessible to the low-income community, there must be some re-structuring of service centers. The Nixon Administration has placed emphasis on the establishment of Family Health Centers and Neighborhood Health Centers.[39] Innovation in this area, however, is inextricably linked to the problem of health manpower. Physicians tend to be white, middle-class and over-professionalized. As a result, they are not likely to be tremendously attracted to working in such centers. The jobs available in such settings are not going to be as well-paying or as prestigious as other opportunities available to the physician. Such centers are also going

to require more primary health care personnel and specialization is the trend among physicians. In spite of these difficulties, a more even distributional spread and more decentralized health care centers are important if medical services are to reach those who have heretofore not been well served.

A last set of goals relates to the inner stucture of the health care industry. A good job, with responsibility and satisfaction, are keystones in any equal opportunity scheme. Certainly the health care industry could provide more, and more meaningful, jobs for minority workers. In order to make access to such jobs meaningful, thought should be given to evolving a less hierarchic personnel structure with more built-in mobility. One way of achieving such a goal is through a greater emphasis on the team approach rather than a highly rigid and hierarchic pyramid with the doctor at the apex. Mobility through on-the-job training is important because stiff educational requirements necessarily deny many qualified and experienced people opportunity.

Underlying any change in the health care structure must be an unswerving commitment to quality control. To talk of change in the health care structure without such a commitment would be a cruel hoax which cannot be countenanced.

B. Alternatives: The Opportunity Area

There are a variety of alternatives available for improving the health care delivery system. The most obvious of these, given the discussion above, is an increase in the number of doctors. In particular, this would be a boon if there were a sharp increase in the number of licensed practitioners who chose to practice as

generalists -- either as general practitioners, family doctors or internal medicine specialists. This would be helpful not only because there would be an increase in the amount of services available, but also because it would result in a decreased degree of fragmentation of care.

It may be feasible to talk of such an increase in the number of doctors: assume for the moment that the constraints of cost and guildism are not such that such a choice is precluded. It would still be doubtful, however, whether this alternative is the one to be sought. An increase in the number of practicing physicians -- even with an emphasis on general practitioners as opposed to specialists -- would not in any way serve the goals listed above. There would be a greater abundance of care available but there would be no greater emphasis placed on the efficient use of manpower. Evidence has been rapidly accumulating that the physician's time could be much more wisely husbanded and that many tasks currently performed by the physician could be adequately handled by properly trained auxiliary personnel.[40] The question of increased productivity has been nicely summarized by Rashi Fein in asking:

> "1. Are there tasks now performed by the physician which could be done as well, or even better, by others?
>
> "2. Are there tasks which the physician performs and which could generally be done as well by others but which on relatively rare occasions involve complications which those less trained could not handle?
>
> "3. Are there tasks done by physicians which, if done by others, would be performed less well, but would, as a result of the increase in manpower supply, be done more often?[41]

There would be no attempt to implement efficiency-oriented innovations if the alternative chosen is an increase in the number of licensed practitioners.

Other important goals would also go by the way-side. There would also be no guarantee that the distribution of health manpower would differ from what it is today. Even with modern governmental financing mechanisms, poorer areas of the city would tend to remain less well serviced. It would still be well-nigh impossible to think in terms of neighborhood primary health centers because of a lack of personnel concerned with manning such centers and equipped to overcome the language and pyschological barriers inherent in such an enterprise. An increase in the number of doctors would merely serve to perpetuate the existing health manpower structure, with the doctor at the very top of the pyramid and no level of health personnel even remotely close by to assist in the delivery of services. The waste of the current system would continue unabated. If there were any alleviation of the shortage of service problems of today, it would not make any change in the way in which services should be rendered or any change in the attitude of the general population about who should be rendering those services. Such an alternative is unacceptable because it is essentially static.

Another alternative is a change in the role of the nurse in the health care structure. There is no single definition of the nurse's role; instead there is recognition of the area of nursing concern. The practice of nursing traditionally focuses on the individual's interaction with an actual or potential illness

or disability rather than on the illness as a separate entity. The peculiar region of the nurse, aside from her administrative and "assistant" functions, is helping the patient cope with the problems of being an unwell person.[42]

The traditional view of the nurse, however, is rapidly changing and it is the nurses themselves who are asking for more and different kinds of responsibility. There has been a fantastic increase in the number of technical specialties into which nurses can and do now move.[43] The rapid advance of biomedical knowledge within the last three decades has been in part responsible for the broader responsibilities of the nurses. Rising expectations of younger nurses has also meant an expansion of expertise in the nursing community.

In spite of these changes, the basic problem which remains is that many nurses are not practicing at their highest potential nor receiving training and experience that would enable them to extend the scope of their practice. At Cambridge City Hospital, for example, it was discovered that nurses were spending large blocks of time on functions they and most authorities consider to be well below their technical capabilities.[44] In addition to their under-utilization of nursing skills, there is also no way for a nurse at the hospital to move up the stratified hierarchy without leaving work and returning to school.[45]

The focus of the nursing profession has traditionally been quite different from that of augmenting the services of the physician. The nurse is usually most active and helpful in the psychosocial area and it is generally there that her expertise is most

required. Nurses have not seen themselves, and have not been seen as, aids toward a more efficient and equitable health care delivery system.

The barriers that inhibit the extension of the scope of nursing and which result in the reluctance of physicians to delegate significant responsibility could be bridged through education and training. The role of the nurse could be expanded and the nurse would therefore play a much more innovative part in the health care structure. A change in the role of this existing body of personnel could achieve many of the goals listed above.

The alternative, expanding the role of the nurse, is an extremely attractive one and recommends itself on many levels. It would permit greater use of an existing level and group of medical personnel and thus be an efficient solution. There would be no need to create a whole new class of medical manpower and go through all of the "birth pains" attendant thereto. It would also render nursing, a traditionally female function, a much more responsible and independent profession.

Unfortunately, it is doubtful that such an alternative is feasible at this point in time. Old definitions are hard to die and it is easier to introduce a new group with a new name via new legislation than to revamp an existing personnel group. A "new" piece of legislation is an immediate and facile boon to the encouragement of innovative thinking; it is much harder to encourage rethinking and redrawing of lines. There is also a danger that an expansion of the role of the nurse, without data to study or comprehend substitutions clearly, and without support

for the internal evolution of jobs, will cast future development first and mainly in terms of a larger labor supply for old occupations. It is essential that any new group provide new services, or a new combination of services, and it is more likely that such innovation will come with the introduction of a new group than through the revamping of an existing group.

A third alternative is the introduction of a new class of medical personnel designed to meet the goals of a more rational and equitable health care structure listed above. Such a group would not enter within the traditional boundaries and inhibitions which the nursing profession suffers from; such a group could be molded, within the constraints of current attitude and law, to the chief desiderata of changes in the heaalth manpower structure. There is widespread interest today in the development of such a level of personnel which is loosely known as the pysician assistant.

It is difficult, perhaps well-nigh impossible, to delineate exactly what tasks this new group could be used to accomplish. In fact, it seems counter-productive to shape one's thinking along such task-lines. The essential thing is that the policy goals sought to be served by the introduction of such a group be kept in the forefront. All thinking about such a new group, including the training required, the existence or type of certification, the function level, the status level, must be geared to the policy goals sought to be served. The advantage of such a new group is that there can be a relatively easy shaping without the constraints of tradition and ingrained attitudes.

Simply put, the physician assistant would serve to increase the productivity of the physician through the allocation of certain of the physician's functions. If some of the more routine rasks were delegated from the physician to an assistant, the physician could utilize his comparatively more economically valuable time for the tasks which require his expertise. This approach would have particular benefits for the neighborhood health center in the poor urban community and in the rural community which suffer from a lack of physician resources.

In addition to the efficiency and distributional impetus, the physician assistant would also be an excellent source of manpower for the neighborhood health centers and the implementation of preventive health programs envisioned to be effected in that setting. Physician assistants could be of the utmost benefit in working with community residents in such programs, particularly if the assistant is a member of the community. Language and professional barriers would be considerably reduced and access to the programs would be facilitated.

In addition to serving the goals of a more efficient and equitable health care structure, it seems likely that the introduction of the physician assistant is the most likely prospect for practical success. There is much interest in such an intermediate level of health personnel. State legislatures across the nation are considering legislation which would, in one way or another, legitimize such a group. Educational programs for the training of the physician assistant have sprung up in many of the major universities all over the country and this will create

pressure for some kind of formal recognition. Although it is not at all clear if or when a national health insurance scheme will be effectuated, many of the current schemes do speak in terms of some form of allied health personnel. While it does not seem probable that there will be positive fruits of such proposals in the near future, the reference to allied health personnel within the legislation indicates that there is a defined recognition of the goal and of that particular option as a viable solution.

It therefore seems most likely that the alternative which is both most satisfactory as a response to the desired goals and as a practical possibility is the introduction of the physician assistant. The term is a popular one and little thought has gone into any exact definition of the role which such an assistant would play in the health care structure. And, as mentioned above, it does not seem wise to delimit the tasks of the assistant at this time. There will be both strictly adjunctive functions -- times when the assistant is working in absolute direct assistance of the physician -- and more innovative functions -- times when the assistant is involved in more independent roles, such as programs which encourage preventive medicine and other forms of community medicine where the assistant could operate more actively on his own. As a definitional matter, however, it is essential that there be some recognition that the physician assistant will be attached to different kinds of physicians and this may call for different kinds of training and expertise. There would be those physician assistants who would perform medical services in assisting general practitioners, internal medicine specialists

and pediatricians. These assistants would be known as the "physician assistant". There would also be those physician assistants who would perform medical services for specialist physicians, and such personnel could be called "physician specialist assistant" or could use the title of the applicable specialty such as "anesthesiology assistant" or "orthopedic surgery assistant". In addition, there would be those assistants who would focus primarily on the development of preventive community health programs in the setting of either a hospital or a neighborhood health center. It is more than likely, however, that such work would be carried on by a team and that the assistant would be working in conjunction with either a generalist or specialist physician.

Such a broad functional definition of the physician assistant is useful for planners, educators and legislators involved in the introduction of this new class of personnel. It is unlikely that any more particular, task-definitional delineation would be useful. In fact, it would be damaging because it then rigidly defines and constricts. The most important thing is that the broad policy goals outlined above be served; there are also specific needs and goals of the physician assistant which will be discussed later. Such a "guidelines approach" is more likely to encourage goal oriented planning and legislation.

C. Inefficiency and Rigidity of Current Manpower Utilization

To say that the introduction of the physician assistant seems the most probable alternative to be adopted is to glide facilely over some very thorny problems. There are severe con-

straints and limitations in the current manpower structure which would have to be overcome before any new group could be introduced in an effective and rational manner. These constraints and limitations are vividly exemplified by the Cambridge City Hospital.

1. Utilization of manpower in the urban hospital: Cambridge City Hospital

Cambridge City Hospital (CCH) is in many ways typical of many city hospitals in this country. It is a modest-sized hospital located in a city with affiliations with a major university. It has been pushed and pulled through a variety of traumata as it changed from a purely municipal institution to a hospital connected with Harvard Medical School.[46] The problems of manpower distribution which face CCH are representative of those facing many hospitals in the United States; however, since it is an urban hospital, many of the problems are compounded.

Beginning in 1967, a pilot study of the Department of Economics of Northeastern University investigated the personnel structure of CCH. The key objective of the study was the exploration of the duties performed by employees in selected paramedical occupations. A second objective was to compare the hiring standards with the actual duties and functions performed on the job to determine whether such personnel was being well-utilized.[47] In order to study this, 87 per cent of the paramedical staff was interviewed. Later, observations were made in order to verify the findings of the interviewing process.[48]

The hierarchy at CCH was discovered to be an extremely rigid one with no possibilities for upward mobility built into the system.[49] Once having entered the structure at level B, there was no way of

advancing short of leaving the hospital and going back to school. Such rigidity might be justified as rational if each level of personnel was used to its fullest extent and interchange among the various layers would be unwieldy; the findings of the study, however, run directly counter to this. The task analysis of hospital personnel indicated that there was a great deal of overlap in the performance of various functions by various categories of paramedical personnel. Although "more difficult" functions do tend to be performed by personnel with higher levels of professional training and knowledge, lesser-skilled paramedical employees often perform these functions also. Lastly, highly skilled persons do spend large blocks of time on functions they and most authorities consider to be well below their technical capabilities.[50]

As a result of the above task analysis, recommendations were made to the hospital to rationalize the use of paramedical personnel. The proposed changes provided for an increased use of lower level personnel to complement and supplant the use of registered nurses and licensed practical nurses on lower level functions. Once having freed the time and energy of these more sophisticated paramedics, their time was to be more effectively used within the framework of three newly defined paramedic occupations: the nursing assistant, the medical assistant, and the physician assistant.[51] The latter two categories mentioned were the most important innovations because they would be in the position to assist the physician in some of the more sophisticated functions traditionally performed by physicians alone. Such a restructuring would make much greater use of a level of personnel just below that of

the doctor and would allow his substantially more expensive time to be used more for those tasks which absolutely require his attention.

2. Institutional structural rigidity

The hiring-in requirements at Cambridge City Hospital are one of the difficulties responsible for the rigid manpower structure of the hospital. The requirements (until modified as a result of the suggestions made by the Northeastern study)[52] were inflexible and, more importantly, had no relevance for the tasks to be performed by each category of manpower. Nurse aides, who performed tasks equivalent to orderlies, were required to have completed high school. Psychiatric attendants, whose functions were equally unspecialized, also had to be high school graduates.[53] No equivalency was permitted for prior experience.

In the instances when practical experience was required, the amount of time demanded was excessive. Hematology laboratory specialists were required to have had three years of specialized practical experience prior to coming to CCH.[54] There were no in-service training programs which would permit an individual to get the necessary experience at CCH while earning a living. There were no opportunities to enter CCH as either a medical assistant or a physician assistant.

The net result of the CCH hiring-in requirements was to automatically exclude many who did not have the necessary academic prerequisites. The arbitrariness of this result lies in the fact that the tasks to be performed by the categories of medical

personnel bear no rational relationship to the requirements. In addition to this, once having entered the occupational structure on one level, there was absolutely no possibility of moving up the hierarchy through on-the-job training programs.

Many institutions are plagued by the kind of structural rigidity present at CCH. In part the problem results from rather "antique" notions of occupation. The technique used by the federal government to classify health workers is very telling. In the manual on health workers, the Health Manpower Source Book classifies health workers by naming their occupation.[55] Classification by occupation is a good first step, but entirely inadequate for an understanding of the health industry's work force because it takes no account of variations and alternatives in job content. These fixed definitions get translated into specifications for training requirements, and are institutionalized via licensure or certification regulations.

Because the occupational listings currently in use do get solidified, all future development is <u>first</u> seen in terms of a larger labor supply for old occupations. The failing of the national manpower-data system is matched, supplemented and complemented by the lack of understanding of labor systems within separate health enterprises, such as hospitals. While computer-based systems can handle the routine accounting functions of hospitals, the unwritten rules of the work place do not become more malleable with the introduction of conventional centralized personnel management.[56]

But even with an elegant, task-analysis approach, hospital information systems would not be adequate instruments of reform.

The main reason for this is that only clinicians -- not administrators or health planners or consumers -- have been the chief arbiters of health-manpower policy.[57] The physician's decision-making context is clinical judgment with the prime consideration being what is best for the individual patient. This clinical judgment, while an important one, is not adequate to tell a hospital how to allocate its resources among patients within the larger hospital framework.

Cambridge City Hospital is an excellent example of a hospital underutilizing its manpower as a result of lack of information of its internal manpower operation, and lack of innovative leadership.[58] Changes have been made in the past year in the hiring structure of the hospital, but it is significant that these innovations came through the force of influence of an economic study done by outsiders. It is possible to effect reform, but innovation is more likely to come from outside rather than from inside the hospital structure.

3. Restrictive function allocation of the law

It is not hospital administration alone which is responsible for the current restrictive manpower allocation. Medical practice acts allow for little flexibility and act as severe restrictions. Licensure has played and continues to play a predominant role in the regulation of manpower inputs into the process of health care delivery.

Licensure of health manpower is a function of state rather than federal government under the power of the state to legislate

for the protection of the health, safety and welfare of its citizenry.[59] State medical societies were successful in securing the enactment of licensure laws in the late nineteenth and early twentieth centuries. At the beginning of this century, licensure of health professionals was part of a general trend towards licensure which included within its sweep such groups as plumbers and barbers.

These statutes, requiring licensure of all persons practicing medicine, were enacted in an effort to combat incompetence.[60] The early laws, originating at a time when there were few health manpower categories, authorized physicians to perform all health care functions. As new categories of health professionals developed and gained acceptance, their members were granted more circumscribed licenses, providing them with some degree of professional status but limiting what functions they could perform.[61] Laws licensing health personnel have typically progressed from permissive to mandatory, making criminal any action within the scope of a licensed profession by one not licensed by that profession. Spheres of action are defined by statute, and boundaries are jealously guarded by each licensed group against encroachment from the outside.

In view of the existing licensure framwork, new types of personnel may perform independent functions only if they are authorized to do so by a licensing statute or by some specific exception to the medical practice act of the state. Massachusetts is a good example of a state currently in the throes of shaping a solution to the problem of credentialling intermediate-level

health personnel. The situation here is that there is absolutely no provision in the law for the introduction of any intermediate-level health personnel. The only exception to the medical practice act is a very narrow one for medical students to enable them to "learn by doing".[62] There would be no room for anyone outside of a nurse to do any technical medical work in the many hospitals or neighborhood health centers in the Boston area. Although it would indeed be myopic to place primary responsibility for the current manpower crisis in health care delivery on the legal framework of that industry, it cannot be denied that the process for regulating the personnel input has made a significant impact on the operation of the system.

4. Response of the courts to the absence of licensure for allied health personnel

As presently structured in most states, the licensure laws do not include a category of medical worker whose training falls between that of a licensed physician and nurse. The physician who uses paramedical assistance finds himself ranged against a variety of obstacles. Not the least of these (at a time when the incidence of malpractice litigation and size of awards are on the increase)[63] is the risk of civil liability based on an injury suffered by the patient during the treatment period.

The usual rule in the determination of malpractice is that the physician is required to possess that degree of knowledge and skill, and to exercise that degree of care, judgment and skill, which other physicians of good standing of the same school or system of practice usually exercise in the same or similar

localities under like or similar circumstances.[64] Thus, it is true that there is some flexibility in current law by virtue of a general delegatory authority under common law. But this flexibility is limited by three factors: first, the court decisions in this area have been based on rigid and narrow construction of medical practice statutes rather than upon broad policy considerations; second, the delegation is open to characterization of "aiding and abetting the practice of medicine without a license"; and third, under the doctrine of respondeat superior, commonly known as the master-servant doctrine, the physician is responsible for the negligent act of any persons in his employ, where such acts are within the scope of employment.[65]

a. Delegation of functions by the physician: inadmissibility of custom and usage

An example of the myopic view of the courts in this area and the consequent constricting influence on the use of paramedical assistance is the decision in Barber v. Reinking.[66] The plaintiff brought an action against the physiician and his practical nurse to recover for injury caused by the alleged negligence of the nurse in administering a hypodermic. The state licensure law said that such a needle could be delivered only by a licensed professional nurse. The court, therefore, held that a licensed practical nurse would be liable if she did not have the knowledge and skill of a licensed professional nurse. The rationale of the court's decision was that the legislature, by licensing personnel and prescribing the scope of practice, had carefully prescribed what is permissible. Permitting expansion of that scope by

permitting the jury to consider evidence of custom and practice in the community would have been, in the court's view, contrary to public policy.

Barber illustrates that a case by case handling of the problem may result in decisions largely inhibiting of change in the area. The jury was not permitted to consider the fact that professional custom and usage in the field were such that use of paramedical assistance was to be encouraged rather than condemned. A fortiori, the potential for liability for the physician because of the negligence of the paramedical is much greater than for licensed nurses. Nurses are licensed by the state; qualificationas are established, and the sphere of activity is defined. The presumption would be, therefore, that the physician is delegating tasks to competent personnel. Currently undefined paramedical personnel would not enjoy that presumption.[67]

Magit v. Board of Medical Examiners[68] is another example of the unsatisfactory approach of the courts. Three foreign specialists, trained as physicians but unlicensed to practice in California, were employed by the defendant doctor to administer anesthetics under his direction and supervision. The defendant was found guilty of violating section 2392 of the Business and Professions Code. In reaching this result, the court held to a very narrow reading of the medicine statutes.

> "Under some circumstances, persons not licensed to practice medicine in California may legally perform some medical acts, including the administration of anesthetics. For example, section 2147-2147.6 of the Business and Professions Code permit certain persons engaged in medical study and teaching at

> approved hospitals to perform acts which constitute treatment of the sick, but no such exception is applicable to the activities of Rios, Celori, and Ozbey at the Doctors Hospital, which concededly was not approved for the training of students or interns."[69]

The important thing was that there was no explicit statutory basis for an exception and there could not be relief from the penal liability for the violation of the statute which prohibited the unlicensed practice of medicine. In addition to this,

> ". . .[a] licensed practitioner who aids and abets the performance of medical or surgical acts by an unauthorized person is guilty of unprofessional conduct under section 2392 of the code even though the acts are done under his immediate direction and supervision. . .The fact that. . .the unlicensed physicians had training enabling them to practice competently did not exculpate the physician who aided them in practicing. This is the necessary result of our statutory system which, in order to assure the protection of the public, requires that a person's competency be determined by the state and evidenced by a license."[70]

The cases above indicate that the flexibility permitted under current law by virtue of the general delegatory authority is not likely to yield fruitful results when the determination is left to litigation in the absence of statute.

b. Consequences of admissibility of custom and usage

In those cases which do allow the jury to consider custom and usage, another problem arises which makes it unlikely that the current statutory scheme will allow for wide use of paramedical assistance. In People v. Whittaker,[71] a neurosurgeon had used a trained surgical assistant to assist in brain surgery. The assistant was charged with practicing medicine without a license even though he had always been under the direct super-

vision of the surgeon. The supervising surgeon was charged with aiding and abetting an unlicensed person in the practice of medicine. Both parties were found guilty. The jury was given the following instructions:

> "In determining whether acts in this case, if any, performed under the direct supervision and control of a duly licensed physician, were legal, or illegal, you may consider evidence of custom and usage of the medical practice in California as shown by the evidence in this case."[72] (Emphasis added.)

The case is significant because of the allowance of custom and usage, but the result was equally damning to the encouragement of the use of paramedical personnel. The reason for this lies in the questionable competence of the jury to devise standards for the sanctioned use of such assistance. The jury, as representative of current community opinion, may be very conservative in such cases. In any event, the result will always be uncertain and inconsistent.

c. Respondeat superior and the determination of negligence

The doctrine of respondeat superior[73] is another judicially enforced impediment to the physician's use of paramedicals. The doctor's liability in these instances would not have to be based on a delegation of medical practice; all that is required is negligence of the employee whether within or without the authority granted to the person performing the task by virtue of his license as a nurse or other kind of medical assistant.[74] In such instances, it makes no difference that the doctor is dealing with a licensed or unlicensed worker. If any employee has been negligent, the physician is held to be fully and vicariously liable.

These cases, however, should not obscure the enormous significance of the violation of medical practice statutes and proof of negligence in those instances where the case does involve acts of an unlicensed medical practitioner. Violation of the statute will be either negligence per se, or merely evidence of negligence, depending upon the jurisdiction.[75] But, an effectively per se result might be obtained under the widespread rule that an unlicensed practitioner is held to the standard of care of a registered physician.[76] A charge to the jury of this kind would seem to demand a finding of negligence, which would be imputed to the employer under respondeat superior doctrine. As a practical matter, therefore, the existence or non-existence of some statutory recognition of the paramedical group has great significance for the imputation of negligence.

d. Criminal liability

The remining possibility for liability under the status quo is criminal liability.[77] If a physician delegates to an unlicensed assistant tasks which could be considered as within the practice of medicine, the assistant may be prosecuted criminally for unlicensed practice of medicine and the delegating physician for aiding and abetting.[78] It should be noted here that custom and usage may be a good defense,[79] but the extra-legal "costs" of time, expense and irreparable injury to reputation have to be considered. Were the physician to be found guilty of aiding and abetting, he would be subject to disciplinary action, possibly even license revocation.[80]

Planning for the introduction of the physician assistant must be set in the background of the goals and constraints outlined above. The goals are much broader than just more medical services. Instead, they include greater efficiency, more equitable distribution and greater accessibility. The physician assistant may answer most, if not all of these needs, but it will not be possible to introduce that new level of personnel without legislative action because of the constraints and inhibitions of the current legal background. The courts are not likely to effect any great change because their results are inconsistent and retrospective.

Legislative action is called for; the main question is what kind of action would be most effective and appropriate. The preceding sections have given us a notion of what we are working from and what we are working toward. The next section is an examination of the various ways of arriving "at the promised land."

III. INTRODUCTION OF THE PHYSICIAN ASSISTANT

A. Goals, Needs and Desirabilities

One of the first needs of the physician assistant is the elimination of the legal barriers which make effective operation impossible. Without the elimination of this barrier, there can never be a full development of the group. An integral part of this is that physicians must be assured that their use of physician assistants will not expose them to both civil and criminal liability. A way of providing such assurance is through the development of some kind of credentialling mechanism, a subject which will be discussed at some length later on.

A system of regulation and credentialling should also provide some amount of security for the new group. It would be a sad, cruel hoax to allow educational programs for the training of physician assistants to develop and flourish and never to provide the group with any sort of definitional recognition. But it must be borne in mind that any system of regulation should be an evolving, sufficiently flexible one so that there can be lateral and vertical mobility of personnel. A flexible scheme with built-in areas for growth and change can take account of new needs, new knowledge and changed technological and social conditions in health services. A rigid licensure scheme cannot provide such flexibility.

The new group must also be officially recognized so that the public will be willing to accept medical services from it. The group must, therefore, be both monitored and legitimized.

Monitored because the public must be protected from incompetent medical treatment; legitimized so that the public will be receptive to treatment from the physician assistant and will not see it as second-class medicine.

Methods for becoming a member of the new group should not be restrictive to members of economically disadvantaged and heretofore unschooled groups. If the physician assistant is to play a more active role in the provision of services to the poor of this country, it is certainly desirable that the assistant come from that group. Language and psychological barriers could be minimized and a more equitable distribution of medical services would result. Connected with the question of distribution is the need to facilitate interstate mobility and ease of change of location. In part, this need goes directly counter to any state, as contrasted with federal, action in this area because state action is in many ways equivalent to barrier building. In this regard, it may be desirable to consider federal participation.

It is unlikely that any one scheme can accomplish all of the goals of the improved health manpower structure and the specific needs and goals of the physician assistant. Tradeoffs and compromises are unavoidable. As a start, it is useful to examine the advisability of credentialling in general.

B. Need for Credentialling of the Physician Assistant

Certainly, there are groups in the medical care industry which have functioned without any state licensure.[81] Nonetheless, for a variety of reasons which will be examined later, some

kind of credentialling system would seem to be beneficial in this instance.

The term "credentialling" is a broad one and can be used to include any one of three terms used to describe the process of formal legitimation of a health care group: registration, certification and licensure.

> "By registration, I mean an arrangement under which individuals are required to list their names in some official register if they engage in certain kinds of activities. There is no provision for denying the right to engage in the activity to anyone who is willing to list his name. He may be charged a fee, either as a registration fee or as a scheme of taxation.
>
> "The second level is certification. The government agency may certify that an individual has certain skills but may not prevent, in any way, the practice of any occupation using these skills by people who do not have such a certificate. . .
>
> "The third stage is licensing proper. This is an arrangement under which one must obtain a license from a recognized authority in order to engage in the occupation. The license is more than a formality. It requires some demonstration of competence. . ., and anyone who does not have a license is not authorized to practice and is subject to a fine or jail sentence if he does engage in practice."[82]

In the case of the physician assistant, there are three groups likely to benefit from the credentialling process -- the public, the physician and the physician assistant. Each group will receive different benefits and we must identify the advantages of each in order to determine an optimal credentialling method.

1. Public benefits

The first function such governmental control would serve would be a regulation of quality control. Initial entrance into

the occupation would be monitored to protect the public from irresponsible delegation of medical functions. In addition to this, a credentialling system could theoretically provide for on-going evaluation which would make certain that the assistant continued to be of sufficiently high caliber. In general, it may be said that a credentialling system could and should provide for accountability to the public.

2. Physician

If the physician is to function as the supervisor for the assistant, care must be taken to permit innovations in the use of personnel with protection for the physician. In general, the physician must be insulated from civil and criminal liability. Although few court decision have imposed liability for exceeding functions defined in the licensing laws,[83] the fear remains and inhibits delegation. If this were not to be altered, the physician assistant would be only minimally used by the physician.

3. Physician assistant

It is for the physician assistant that the greatest benefits would accrue as a result of credentialling. The first positive result would be the definition of status and the psychic benefits of at least nominal definition. To the extent that one judges professional associations and organization a positive goal, credentialling does encourage this phenomenon.

Probably the most important positive gain of some form of creditialling for the physician assistant is that of job security. An example of how a lack of credentialling operates in practice is instructive. In the summer of 1969, a graduate

of the Duke Physician's Assistant Program went to work in a California clinic staffed by nine physicians. After functioning for some months, without incident and to the satisfaction of his employing physicians, the physician assistant was informed by the business manager of the hospital that it was advisable that he procure a formal legal opinion of the scope of his functions and potential hospital liability. The opinion of legal counsel was that the physician assistant would have to be confined to the activities permitted to an aide or orderly.[84] Subsequent to the rendering of this opinion, the directors of the clinic where the physician assistant was employed determined that they could not assume the risk of the assistant's continuing to perform tasks not sanctioned by the opinion and he was restricted to the tasks of an orderly.[85]

The harshness of the above result can only be mitigated if there is a system of credentialling so that the physician assistant need not worry about subsequent, restrictive changes in policy. The fact that there is so much uncertainty about the future of the physician assistant when there is no credentialling process, inhibits vertical mobility of personnel. Nurses or ex-corpsmen who would be qualified to serve as physician assistants cannot do so.

The uncertainties inherent in the current situation are not conducive to innovation in the health delivery system. Classification of the legal position of the physician assistant would be to the advantage of the public, the physician and the physician

assistant. Some thought must be given to deciding on the general type of legislation which would be most advantageous.

C. Alternative Methods of Credentialling

1. Maintain the Status Quo

Because physician assistants will function in a dependent relationship with physicians, it would be possible to gain eventual protection through developing custom and usage in the profession.[86] This approach presents a number of disadvantages which make it unacceptable. The main difficulty here lies in the work "eventual". Today, the parties involved would not be relieved of financial and professional risks inherent with the lack of legislative sanction. As a practical matter, the possibility of such liability might preclude the effective utilization of the physician assistant.

In view of the time and energy investments required for a completion of a training program, there is also an ethical obligation to the physician assistant to provide some assurance that there will be a legitimate place for him/her in the medical community. The present situation also provides no protection for the public in the form of standards and qualification requirements for persons in this capacity.

2. State licensure

The most obvious means of credentialling is to create a new category of license similar to the licensure of other health personnel. The advantages of such a move are obvious: the alleviation of some of the dangers of civil and criminal

liability discussed above; the enhancement of the status of paramedicals as an occupational category; the protection of the public through the specification of minimum qualifications.

Such a scheme, however, would be unsatisfactory. There is too great a tendency to fragment health care delivery and to freeze function-allocation at what later would be unrealistic levels. At a time when there is a clear need for a full-scale re-evaluation of the efficacy of licensure even for those health professions currently regulated in that way, it would not be a desirable solution to lock physician assistants into a rigid licensure scheme.

An additional argument against licensure is posed by the very concept of the physician assistant. Although the assistant receives a core of basic background knowledge and skills through participation in the formal training program, it is intended that his education should continue throughout his work experience. New skills would certainly be acquired over time and new understandings gained as the assistant becomes more familiar with the practice. A scope of practice specified for the recent program graduate might impose an unjustifiable ceiling on the graduate with a number of years' experience. This diversity of experience and the consequent diversity in capability would pose a significant obstable to the formulation of a realistic definition of the scope of practice for physician assistants.

A strict licensing scheme would also adversely affect the career mobility of people in the health field. A person at

one level or with one particular license who wishes to move up the ladder or expand his range of performance may be required to enter a formal education without receiving much credit for prior education and experience. This may in fact preclude advancement for those whose financial responsibilities prevent a return to school. The obstacle to advancement thus imposed will often be logically unjustifiable in view of the skills and knowledge which have been acquired in the course of work experience.

3. Statutorily created exceptions to medical practice acts

In a number of states, the legislature has attempted to solidify and delineate the delegatory power of the physician[87] by enacting general delegatory statutes. Arizona, Colorado, Kansas and Oklahoma have done so.[88] Each of these statutes is a briefly-worded exception to the usual statute making it illegal to practice medicine without a medical license.

a. Non-specific permissive statutes

The most permissive and expansive of the statutes within this rubric is the Oklahoma statute which reads as follows:

> "[N]othing in this article shall be construed as to prohibit. . .service rendered by a physician's trained assistant, registered nurse, or a licensed practical nurse if such service be rendered under the direct supervision and control of a licensed physician."[89]

Under Oklahoma law, both R.N.'s and L.P.N.'s are licensed. Their fields of practice are limited by their own licensure laws. Only the category of "physician's trained assistant" is left undefined. It is a rather broad phrase and could be said to cover many of

the new categories of assistants. In spite of this strength, the statute is open to weighty criticism as legal support for the extensive use of physician assistants. These limitations include: (a) no protection for the public against the use of unfit personnel; (b) use of vague terms like "under supervision and control" without any clear guidelines for the physician; (c) lack of definition of the term "physician assistant" -- is this a generic category of practitioners or a specific type of practitioner? and (d) the supervising physician is left fully responsible for the malpractice of the assistants.

The disincentive effect of this last limitation is not to be underestimated. The supervising physician has little legislative sanction to rely on. No examining agency or explicit statutory provision condones his choice of assistant under a statute as broadly worded as the Oklahoma example. The physician would thus be vicariously liable for any act of malpractice by such an assistant, even if his own instructions and supervision were without fault.

b. Specific permissive statutes

Another approach in credentialling allied health personnel is a specific type of delegatory power. Thus, rather than a general power of delegation, the physician might be given the express power of delegating to only one type of health care professional. This is the course taken in Colorado[90] with the "child health associates" trained as assistants to pediatricians at the University of Colorado.

The particulars of the Colorado plan are a laudable attempt to protect the public against inadequately trained health personnel. It provides minimum training standards for the personnel as well as considerable detail about the supervision required. The activities of the associates are strictly limited and there must be a one-to-one ratio between paramedic and physician.

While such a scheme does protect the public, it does suffer from many of the limitations of a strict licensing statute. The question which must be raised is whether specifically authorizing delegation to one type of auxiliary practitioner implies that delegation to others is not permissible.[91] The fact that the statute sets out such detailed requirements means that those without the specific prerequisites, i.e., Armed Forces medics, are barred from participation. More broadly, no other experimental programs to produce similar personnel can be developed in Colorado, or imported from other states, except in accordance with these strict guidelines. The rigidity of the specific delegatory scheme greatly limits its usefulness.

4. Establishment of a "credentialling agency"

This approach calls for the establishment of a committee or board to certify paramedical personnel. An example of this is the California "Physicians' Assistant" law.[92] The first thing to be noted is that the California law is a registration act and not a licensing act.[93] It authorizes approval by the State Board of Medical Examiners of the hiring of physician assistants from approved training programs.. The legislation is broadly drafted

and leaves to the Board the task of developing criteria and standards for such training programs. Most importantly, the law specifically allows and encourages the utilization of equivalencies to give full credit to trainees for previous education and experience.

As to scope of service, the new California law merely authorizes such assistants to perform "medical services", undefined, under the supervision of a physician or physicians approved by the Board. Like Colorado, the law requires the Board to approve specifically the physicians who are allowed to supervise such assistants. The California law also restricts the number of such assistants who can be supervised by one physician, but allows two supervisee-assistants, where the Colorado law allows only a one-to-one ratio.

Massachusetts is considering legislation which would introduce the physician assistant via a credentialling agency.[94] The Massachusetts proposal varies somewhat from the California scheme. Instead of adding this task to the slate of the Board of Medical Examiners, as was done in California, there is to be established within the Department of Public Health, a Board of Certification and Utilization of Physician Assistants, consisting of nine persons including: three physicians, one representative of a medical school, one registered nurse, one teacher in a program for physician assistants, one hospital administrator, one physician assistant and two consumers.[95] The duties of the Board are two-fold: the accreditation of educational programs

within the Commonwealth which shall train the physician assistant and the certification of individuals as graduates of approved programs.[96]

In setting standards for both the programs and the individuals, the Board is encouraged to give weight to practical experience. In the case of the training programs, the Board is to develop criteria which encourage programs to utilize equivalency testing which give full credit for past experience in health fields.[97] In the case of individuals, the Board is empowered to formulate guidelines for the consideration of applicants. The application form is to include the qualifications, including related experience, of the physician assistant.[98]

The exact tasks to be performed by the physician assistant are not spelled out in the Massachusetts proposal. But it is clear that a wide breadth of services is envisioned. The assistant may perform general or specialized medical services depending upon his level of professional training and experience.[99] The Board is empowered to examine the qualifications of the assistant as well as the professional background of the physician and a description by the physician of the way in which he plans to utilize the assistant.[100] In the event that the assistant is to be employed by a hospital, or other health facility, the Board shall consider the background of the assistant and shall formulate guidelines for the scope of employment of the assistant. The Board has been given very wide discretion in the determination of the scope of services which the assistant shall be able to perform.

At the same time, the physician must still assume the responsibility for the actions of the assistant. The physician is to be permitted to supervise two assistants at any one time; in addition, the assistants need not render services in the physical presence of the physician.[101] This would seem to be a somewhat liberal approach in that it does not constrict, at least physically, the work of the assistant. But the proposal takes a very strict and explicit view on the issue of liability. The work of the assistant is to be the legal responsibility of the physician. Even when the assistant is an employee of a health care facility, the physician and not the health care facility is to be held liable for the negligence of the assistant.[102]

The essential point to note about the credentialling board schemes is that the draftsmen have placed a vast amount of discretion and power in the boards. The underlying problem is whether the board acts effectively and aggressively in developing regulations to guide the performance of practitioners. As we shall see later, the performance of the California Board has been less than heartening.

5. Federal legislation

a. The desirability of federal action

There are a number of reasons for wanting the federal government to act as the credentialling body for physician assistants. First, federal standards would eliminate the problem of geographic wall-building. An argument can certainly be made that the current state licensure schemes impede the

inter-state travel of citizens.[103] This reasoning may be questionable for a physician or nurse who can always take an examination in another state. It is much more persuasive for the allied health personnel group because of the wide disparities among the states. Most states have enacted no credentialling schemes at all; some have only a general delegatory system; California alone has organized an agency to administer credentialling. It is not merely question of taking another examination. In some instances it would mean not being able to practice at all. Such differences certainly could affect the freedom with which citizens can exercise their constitutionally protected right to travel interstate.

In addition, it is likely that only with federal action would there be an incorporation of other important policy goals, including the encouragement of minority group participation. In the Kennedy proposal, for example, the Board is specifically instructed to encourage the education and training of persons disadvantaged by poverty, race and inadequate education. To this end, remedial and supplementary education is to be provided.[104] Important social policies such as this must be set and encouraged by the federal government; state action is much too uncertain.

A federal credentialling scheme would also provide minimum uniform requirements. This would be some guarantee of basic qualifications. It might be argued that it is wise to leave the states enough flexibility so that local needs and conditions can be suitably responded to. Here, it is important to note that

the federal standards need only be minimal; room can be left for cooperative state action.

Perhaps most important is the political reality of the health care industry. The professional and occupational groups that are reluctant to innovate in the credentialling area are strong voices in the state legislature. Their influence on the state level, via fifty points of resistance, makes any chance of reform in this area a very dim one. It would, therefore, be difficult to achieve nationwide reform by working through the individual states. Federal action is very much needed if this goal is to be achieved.

b. Traditional exercise of state power

Traditionally, laws relating to licensure have been included within the ambit of police power. The police powers of the state were defined in Nebbia v. New York[105] as:

> "They are nothing more or less than the powers of government inherent in every sovereignty to the extent of its dominions. . . It is by virtue of this power that it legislates; and its authority to make regulation of commerce is as absolute as its power to pass health laws, except insofar as it has been restricted by the constitution of the United States."[106]

More recently, and more specifically, the court explicitly pointed out that the state's broad power relative to the health of its citizens extends naturally to the regulation of all the professions concerned with health.[107] The state licensure laws enacted pursuant to this power are designed to protect the public from incompetent, unethical and unscientific practitioners.[108]

c. Existence of federal power

In spite of the historical weight on the side of the state exercise of police power, it seems clear today that federal constitutional power can be found lurking in the eaves waiting to emerge. The source of this power lies in the Commerce Clause. The great case which sets the stage for federal entrance is Wickard v. Filburn.[109] Prior to Wickard, the federal government could act under the Commerce Clause only if the activity exerted a direct, rather than indirect, effect on interstate commerce. This distinction was demolished in Wickard with the Court holding that even a purely local activity which is not regarded as commerce, may be regulated by the federal government if it exerts a substantial economic effect on interstate commerce.[110]

The most expansive reading of the federal power contained within the Commerce Clause was accomplished in Katzenbach v. McClung.[111] In enacting the Civil Rights legislation of 1964, Congress had legislated a conclusive presumption that a restaurant affects interstate commerce if it serves food to interstate travelers. This was done in lieu of a fact-finding study. The district court found such a presumption invalid and held that Congress would have to designate the connection between food and discrimination.[112] The Supreme Court reversed, and in the process, opened up the broad gates of legislative supremacy under the Commerce Clause. The only activities that are beyond the reach of Congress are:

> ". . .those which are completely within a particular State, which do not affect other states, and with

> which it is not necessary to interfere, for the purpose of executing some of the general powers of the government."[113]

Little need be said after such a statement.

In addition to this broad sweep given to Congress, the Court laid down very minimal evidentiary requirements. No formal findings had been made by Congress about the connection between food services and discrimination; the Court held that none need be made. If the legislators had a rational basis for finding a chosen regulatory scheme necessary to the protection of commerce, that was sufficient.[114]

There is little doubt that the federal government could enter into the health personnel credentialling field under the standards set down in Katzenbach. The delivery of health care services certainly has a substantial effect on interstate commerce. The fact that one state will or will not credential health personnel will have an impact on the flow of people and drugs and medical equipment among the various states. The conclusion that there is Congressional power is insured by the fact that Congress need only have a rational basis for deciding this question in the affirmative for legislation to be upheld by the Court.

d. Supremacy clause

Once having enacted legislation in the area, what would be the relationship between state and federal law? Presumably, the federal law could completely supercede existing state programs; instead, however, it would probably be largely interstitial.[115] Under such circumstances, the two layers of legisla-

tion could coexist until the act of Congress and its standards would come into actual conflict with the law of the state.[116] Once such a conflict could be actually said to exist, the state regulation based on police power would have to yield to the weight of the federal program.[117]

e. Form of federal action

The federal government has already taken some action in this area by announcing a federal civil service position designated for the physician assistant.[118] The announcement does not set out the specific task structure of the physician assistant, leaving that to the specific work situation. The main thrust of the announcement seems to be to recruit personnel to work in the hospitals and clinics of the Veterans Administration with smaller numbers needed in the Indian Health Service and the Bureau of Prisons Health Program.[119]

In order to qualify for the position, the candidate has to have completed a formal twelve-month physician assistant program or its equivalent. In addition, three years' work experience as a medical corpsman, nursing assistant or medical technician is required.[120] Each candiate is to appear before a panel of medical doctors to determine the exact level of responsibility he can ssume and his pay scale.

Such a program allows for hiring physician assistants in the federal civil service. It does not speak to the problem of manning state and private institutions and is not a national qualifying procedure. In order to achieve this latter goal, it would be necessary to set national standards of competency which

would serve to guarantee basic qualifications to the public and basic credentialling to the physician assistant. Each state could add on requirements which are particularly relevant to the environment of that state. These state requirements would be permitted to function as additional screening mechanisms as long as they did not conflict with federal standards.[121] A two-layered mechanism would permit the setting of minimal federal requirements with flexibility to allow for interstate differences.

IV. POLICY PROBLEMS WHICH EMERGE FROM THE SCHEMES: HOW THE PLANS STACK UP AGAINST THE GOALS

Ranged against the specific statutory solutions described above are policy problems which any systematic change in the health care area would have to grapple with, and broad objectives which change would ideally move toward. It seems generally agreed that the objectives of any reform in the professional licensure systems should concentrate upon the increase in total supply of health manpower, and removal of the rigidity in current laws which make change and mobility so difficult. An important caveat here is that such changes should not be sought at the expense of public welfare in terms of the quality of health personnel. The particular policy issues which are significantly involved in the credentialling schemes are (a) educational requirements for the physician assistant; (b) scope of care; (c) liability of the physician; and (d) standard of care to be applied by the courts in adjudging the negligence of the physician assistants.

A. Educational Requirements

The issue facing the planner of the physician assistant's credentialling system is what formal education and training are necessary to assume specific functions and to progress to positions of more responsibility within the manpower hierarchy. Should there be intensive on-the-job training programs or an emphasis on traditional associate degree and baccalaureate programs?

The choice of one kind of educational requirements over

the other has significant policy implications. If a state credentialling program requires completion of a certain number of college level credits in specified subjects, the veteran who has only completed high school or its equivalent will be effectively eliminated from the potential pool of physician assistants. Meeting these requirements could mean a delay of three to four years for a typical high school graduate veteran. Such a rule would be particularly onerous on minority groups who lack the formal academic training.

A credentialling program which is not geared to on-the-job training will also make it virtually impossible for those with financial responsibilities to participate. Nurses and medical technicians who are currently working in hospitals and clinics, and who would have interest in becoming physician assistants, would be forced to leave their jobs for at least one year. The hardship imposed by such a requirement is obvious.

In addition to the practical problems raised above, there are certain underlying policy problems relating to educational requirements. A stress on academic achievement and knowledge may be an effective method of maintaining the education level of health workers, but does it ensure the maintenance of high quality practice? Even if one is willing to accept the validity of the initial credentialling on the basis of academic achievement, perhaps there should be a method of certification of acceptable performance in continuing education programs or on the basis of challenge examinations.[122]

Because the specific educational requirements in the law may block entrance and impede career mobility of persons with considerable, if unorthodox, background in the physician assistant's role, it would be useful to consider permutations on rigid prerequisites. Proficiency examinations are now being developed in various disciplines to measure a person's competency to perform certain jobs.[123] Equivalency examinations are also being developed to equate nonformal learning with that achieved in academic courses or training programs.[124] The credentialling program should provide sufficient flexibility in governing initial minimum standards of qualification to recognize alternative education and experience as equivalents of formal academic training. Another related need is that the standards allow for, and positively encourage, lateral and vertical mobility through on-the-job training.

B. Scope of Care

There is a considerable spread of opinion about the duties, functions and responsibilities that can, and should, be delegated to paramedical personnel.[125] For purposes of this discussion, however, the important point to note is that the underlying objective of a non-rigid occupational scheme would argue for a system which allows for change as the physician assistant becomes more skilled.

The most obvious approach to adopt in defining the scope of care is to do what most of the states which have acted in this area have done: leave the decision in the physician's hands

within the parameters set by the medical practice acts.[126] Such a delegatory statute accomplishes little because the physician has no guidelines and, faced with potential civil and criminal liability, is likely to err on the side of delegating too little rather than too much. The public welfare is also not sufficiently protected by the vague language of a general delegatory scheme.

It is also possible to mimic Colorado and very specifically set out the terms of permissible scope of care in the statute.[127] As noted in the discussion of the Colorado scheme, the pitfall here is that the validity of delegations to persons other than those enumerated is called into question, and this could result in a possible contraction of common law delegatory authority.

The most attractive scheme on paper is the delegation[128] of permissible paramedical activity to a state board of medical examiners as was done in California.[129] In California this board is made up only of physicians.[130] But certainly, a proposal could theoretically call for the establishment of a health manpower committee or board consisting of all the principal categories of medical personnel and lay representatives as well.[131] The advantage of using an administrative body to set the standards is that it has institutional flexibility and the capacity to adjust to meet changing public needs.

Scope of practice could be set either through the Board setting minimum requirements for a specifically designated area of

medicine or on an ad hoc or individualized basis. The California proposal calls for the latter.[132] The ability to adjust the functional sphere of new paramedical types is very appealing; new types of manpower could be rapidly integrated into the industry.

As appealing as an administrative delegatory scheme looks on paper, the implementation poses a substantial stumbling block to be overcome.[133] The most threatening "Spaniard in the works" is that the board will be loathe to take innovative steps because this might pose a threat to the established profession. In this regard, it will be instructive to examine the effectuation of the California scheme for the results of a machine in action.[134]

C. Liability of the Physician

One of the keys to a successful paramedical program is the question of the physician's liability in malpractice litigation. The underlying framework, including respondeat superior and traditional tort principles, has been set out earlier.[135] It is logical and clear that the risk of liability is a strong inhibiting influence in the effective use of health manpower.[136] It is also clear that the greater the risk, the less likely it is that physicians will use and use fully the physician assistant.

The general delegatory statutes[137] will not change the current malpractice liability of the physician in any appreciable way. Because the statutes are so broadly written, they afford little protection for the physician when under attack for wrongful

delegation. As under common law, the physician will be able to rely only on "custom and usage" and the "locality" rule.

The more specific delegatory schemes do reduce the risk for the physician. Because the exact requirements are so minutely spelled out, the physician can ascertain precisely the limits of delegation and thereby insulate himself from liability. Although this genre of scheme does have this advantage, it is undesirable on other grounds.[138]

We again turn to the administrative credentialling plan embodied in the California proposal. There are a variety of questions raised here for which there are no readily apparent answers. The California scheme, as noted before, is a credentialling and not a licensing scheme. The individual paramedical is sponsored by an individual doctor for a particular role allocation. Thus, the paramedical is not within a formally (by the legislature) licensed group like nurses; he is also not merely a delegateee under the old common law system. Would a court faced with the problem of determining the liability of the physician construe the credentialling by the Board to be equivalent to a license and reason accordingly? Or would the court take the credentialling procedure merely as indicative of legislative intent? Most importantly, could a physician be sure of the answer to this question prior to litigation?

This problem is interrelated with another concern raised earlier. If the Board is unduly restrictive in its establishment of standards of scope of care or supervision, there will be

ramifications for malpractice liability. Every time the standard set by the Board is breached, it will be a violation of law which can be used against the assistant, his assigned master, and the institution or group which hires the assistant. If anything goes wrong in the treatment of a patient, the master-supervisor will continue to be liable for the malpractice of his assistant. In fact, his very failure not to supervise closely and his allowing others to share in that supervision could alone be the basis for an allegation of malpractice due to the fact that it would constitute violation of statute law.

Certainly, there are valid reasons for retaining the traditional doctrine of respondeat superior.[139] The problem would seem to be that rigid adherence to it overlooks the change in occupational status of paramedical personnel and may be inhibiting of innovations in this area. Whether or not this could be altered, without jeopardizing public safety, is a question explored in the next section.

D. Standard of Care for Adjudging Negligence of the Physician Assistant

The doctrine of respondeat superior holds the physician liable for the negligent acts of his paramedical employees when they are an unlicensed group and the employee is acting under the delegatory authority of the physician. Once a state legislature acts to credential allied personnel through one of the methods discussed earlier, the question is raised whether the physician-employer should still be held to the same standard. This question can only be answered in the context of the policy underlying the

traditional tort dogma.

The primary reasons for maintaining respondeat superior are those of adequately protecting the public. A patient can be confident that if he is injured by an insolvent paramedic, a substantial judgment in his favor could be satisfied by the physician-employer. In addition, and more importantly, the threat of liability is a significant means of ensuring that the physician will exercise adequate control and supervision over the medical activities of an assistant. These policy reasons are substantial and any attempt to alter the responsibility of the physician would, of course, have to be very carefully scrutinized.

At least some of the force behind these policies is removed with a credentialling scheme for allied health personnel. This is particularly true when the state adopts a scheme like the one in California which involves active participation by a medical board. When regulations promulgated by a medical board set standards for physician supervision over an assistant and the scope of his practice, the value of respondeat superior as an incentive to the physician to use the assistant with caution is greatly diminished. If respondeat superior continues to remain applicable under such circumstances, it will merely compel the physician-employer to stand as an insurer of his assistant. Such a position is unacceptable when the paramedic's role entails a high degree of professional judgment and expertise.

Given the fact that we may decide to move out of the dark ages when only the physician was seen as a responsible party

in a case of medical negligence, some revision of respondeat superior as it applies here may be appropriate. Theoretically, a revision could follow these lines:[140]

> (1) When the assistant has been delegated a task which requires an exercise of his own professional judgment and skill, then he should bear the burden of liability.[141]
>
> (2) When the assistant is acting only as an extension of the doctor, the doctor should be liable if the function is medically improper and the assistant should be liable for lack of skill in the execution.

There maybe mammoth problems of evidence and proof in given situations which argue against the adoption of such a revision; it would seem to this writer that the advantages cannot be overlooked.

The first advantage is that it would encourage physicians to use paramedical assistance; the threat of respondeat superior is a weighty disincentive. In addition, the recognition of physician assistants as a group responsible for its own negligence would be a psychological boost to the development of professional independence.[142] To the extent that one believes that a self-image of professionalism is a beneficial one, this change would be adjudged a good one.

Once having, at least theoretically, established the need for a revision of the concept of respondeat superior, it is

necessary to determine what standard of care the paramedic "community" would be held to. The assistant could either be held to the standard of care of the licensed physicians or to that standard developed particularly for the assistant. The establishment of a different standard for physician assistants from that which is used for doctors may have certain important "public relations" problems. The public may be very loathe to accept health care not administered on the level of the physician. The policy problem raised here is that there must be educational programs devised which will make the public aware of the fact that others than physicians can deliver competent medical services. Such an educational program would be no mean feat in this country which has never seriously considered the option of qualified paramedical assistance.

Even if a concerted effort is made to educate the public in this way, ready public acceptance is still many years away. In the meantime, the unfortunate consequence of this lack of acceptance is that the poor would be forced to swallow what was offered; those with means would still be permitted to exercise choice. On the other hand, it is difficult to justify holding the assistant to the standard of care of the physician. Such a decision would limit the potential effectiveness of the program by forcing the assistants to be overly cautious and restrained.

In balance, it might seem wisest for the courts to adopt a separate standard for adjudging the negligence of the physician assistant.[143] Initially this would be a difficult task because

preliminary use of physician assistants will be largely experimental. Custom and practice will not provide a reliable frame of reference and the courts will turn to legislative and administrative regulation. It is, therefore, essential that the administrative bodies provide clear guidelines as to the standard to which the physician assistant should be held.[144] Most important of all, of course, is the clear need for each assistant to be required to purchase malpractice or negligence insurance.

E. Implementation of the Credentialling Agency: The Slip Between the Cup and the Lip

As mentioned earlier, the major administrative hurdle in California was the implementation of the new physician assistants' statute by the Board.[145] While the statute called for broad encouragement of the program, the power to promulgate specific regulations was given to the State Board of Medical Examiners. It was the Board's responsibility to put into concrete terms educational requirements, scope of care and physician supervision. The process leading up to the promulgation of rules is instructive because it was an interplay of forces between the Medical Board and counter groups. In October of 1971, fourteen months after the enactment of the statute, the Board of Medical Examiners proposed a very stringent set of regulations for physician assistants.[146] A public hearing was held on November 20, 1971, at which time the important policy differences between the Board and the Advisory Commission and other groups were heard. The Board did alter its position in a number of important respects, leading to the final regulations.[147]

1. Educational requirements

The initial regulations proposed by the Board of Medical Examiners required that each candidate have completed a certain number of junior college level courses before being allowed to apply for admission to the physician assistant training program. The college level courses included math, English, American history, anatomy and physiology, microbiology, sociology or cultural anthropology, and psychology.[148] The final regulations of the Board cut back on these academic requirements for admission to the physician assistant training program. A candidate for admission is required only to have completed high school or have passed a standard equivalency test.[149]

The proposed entry requirements were objectionable on at least two grounds. First, the requirements automatically excluded candidates who by virtue of extensive training and experience in the health field are demonstrably suitable for direct entry into health care assistant training programs. Many former military corpsmen, nurses and foreign medical graduates have not taken college level algebra, psychology and sociology. Since such deficits would have to be made up before a training program could accept them, potential candidates with these deficiencies might not be willing or able to assume this financial burden. Second, in addition to their being unduly stringent, the entry requirements were questionable as to their relevancy. Rather attenuated arguments could be made for the general desirability of having studied college American history and sociology, but

these arguments are not of sufficient weight to justify the imposition of these academic barriers which will discourage many able and motivated individuals from entering the new career.

The adopted regulations obviated the college level entrance requirements but retained a heavy academic emphasis in the structure of the physician assistant training program. Course work must include junior college level mathematics, English, anatomy and physiology, microbiology, sociology and psychology. In addition to these courses, the program must also include instruction in clinical science courses such as history taking and physical diagnosis, therapeutics, medical terminology and common laboratory and screening techniques.[150] The minimum amount of time permitted for the completion of the training program is one year, no matter what the candidate's previous background includes.[151] At the end of this time the student shall receive an Associate of Arts or Science Degree.[152]

The course of instruction for the physician assistant with its emphasis on academic requirements suggests that the Board believes the assistant's tasks demand extensive theoretical rather than practice foundation. This supposition is certainly open to question. In addition, one must place the academic requirements of the program in the context of the task allocation for the physician assistant proposed by the Board.[153] The allocation places little credence in the physician assistant's capacity even after this rigorous academic program. One is left wondering why all the coursework and credits were necessary.

The strict time strictures are another weakness of the California educational requirements. A three-month preceptorship is required by the Board in order to successfully complete the program.[154] The entire course of study must take at least one year to complete. The mandatory limit of three months for the preceptorship may be altogether too short for someone who has not had experience with patient contact and unnecessary for anyone with much experience. The time requirements of the training should depend entirely on the background of the individual. A nurse who has worked for years in a hospital or clinic may not need as much training as a recent high school graduate with no health care experience. The arbitrariness of the time limits is particularly striking because the physician assistant's role is to be primarily a practical one and the time limits bear no rational realtionship to this role model. Flexibility for accommodating a variety of backgrounds has been replaced by a rigid (time and structure) formula.

2. Scope of care

The Board of Medical Examiners has set out specific tasks which the physician assistant can perform.[155] The task list is set out "specifically and by way of limitation", which means that other tasks can be added to the list only if the Board formally decides to change the regulations. This restriction does not permit the physician to delegate more to the assistant if the physician believes that the assistant is fully capable of performing the tasks. Such an approach does not encourage professional growth by continuing education. Nor does it take

into account new techniques and procedures that may be developed through medical technology. In order to add to the list the Board would have to formally convene, which is a lengthy process requiring prior publication, hearings and other administrative agency appurtenances.

The actual list[156] of tasks, because it is a specific and limiting list, omits tasks which are of the same order as those allowed. Thus, a foreign body may be removed from the skin, but not from the conjunctiva; imparted cerumen may be removed from the rectal canal. The very nature of such a list dictates arbitrariness and it would be picayune to point to these illogical aspects of the exclusions. The more important criticism is that the flexibility and growth factor encouraged by the statute is not present. While it is essential that there be control over the physician assistant to safeguard the public welfare, a more balanced mix of control and flexibility could have been adopted.

3. Physician supervision

The regulations concerned with physician supervision[157] resulted from a compromise between the original Board proposal and the countervailing arguments of other groups. The proposed regulations called for "physical presence of the primary care physician to reveiw findings of the assistant. . .and to consult with said assistant. . .before and after the rendering of routine laboratory and screening techniques. . ."[158] The language of the proposal was unclear on whether "physical presence" meant

that the physician was to be physically available for review and consultation, or if the physician had to be physically present with his assistant at the time of review and consultation.

The regulations finally adopted by the Board are more explicit on this point. Supervision refers specifically to

> "The responsibility of the Primary Care Physician to review findings of the history and physical examination permitted by section 1379.23(a) and all follow-up physical examinations with said Assistant. . .at the time of completion of such history and physical examination or follow-up examination and to consult with said Assistant . . .before and after the rendering of routine laboratory and screening techniques and therapeutic procedures. . ."[159]

It is clear from the above that the physician must actually be physically present with his assistant and patient at the time of review and consultation. The physician must also be consulted prior and subsequent to the rendering of routine laboratory and screening procedures.

The first undesirable consequence of this requirements is that the demands on the physician for supervision are so great that the physician wanting to adhere conscientiously to the provision would not employ an assistant. The time and energy consumed by supervising activities and the interruptions in the flow of work would not be compensated for by having an assistant.[160]

If a physician hired an assistant knowing that the provisions of this section are almost unenforceable because of the impossibilities of surveillance, he might be inclined to circumvent the restrictions. This would also be an unfortuante

consequence of the requirement because it encourages contempt for the law. The requirement also would not ensure quality of health service for the public.

A final unfortunate consequence is that the supervision requirement, taken in conjunction with the limited task allowance, greatly inhibits the professional growth and confidence of the physician assistant. The irony of the situation is that the Board has gone to such pains to require substantial academic achievements from the assistants. Once having passed through this training, the physician assistant is given none of the responsibility and flexibility commensurate with that rigor. This result calls into question both the validity of the training mechanism and the strictures on allowable duties.

The California regulations are an example of innovation gone awry in the hands of an adminstrative agency. It is certainly questionable whether the adopted regulations meet the statutory mandate "to encourage the utilization of physician assistants and to allow for innovative development of programs for their ecucation."[161] The experience in California makes one wonder about the efficacy of the credentialling agency. Perhaps the likelikhood of professional dominance and calcification is so strong that the board scheme is unworkable. There is room for a wide credibility gap.

One of the factors which may be isolated in California is the fact that the Board was composed solely of doctors. The presence of other influences -- educators, nurses, medical economists, consumers -- might make a significant difference in

final product. Perhaps also when some time has passed and the public does not automatically shudder at the thought of less-than-physician care, greater flexibility would be permitted. The change must be one of attitude. The notion that the physician, and the physician only, can adequately perform health services, may be responsible for much of the rigidity reflected in the California regulations. Only with the death of this notion and some acceptance of the evidence that certain health services can be provided adequately and safely by persons with substantially less taining than the physician, will there be any innovation.

V. CONSEQUENCES OF THE INTRODUCTION OF THE PHYSICIAN ASSISTANT

In order to evaluate which of the alternative routes would be most effective, it is essential to guage some of the problems which one can predict will emerge after the introduction of the physician assistant. Some of the difficulties likely to emerge have already been alluded to: the possibility that the credentialling agency will adopt a very rigid and restrictive approach to its role of defining both the training and the scope of the physician assistant; the likelihood that public attitude will inhibit the development of the new group. In this section, I will examine the problems which are likely to emerge within the internal workings of the health manpower structure.

A. Problems of Role Definititon

1. Fragmentation

As noted above, an unfortuante emphasis has been placed on the shortage qua shortage of allied health manpower. In part this is a result of the misleading classification systems which lead to a biased evaluation of health manpower. An example of this is the Health Manpower Source Book.[162] Because this system simply counts bodies in the work force as classified by their occupation, the system provides no data on substitution. It does not indicate the kind of organized delivery system or the part of the country in which nurses are performing tasks conventially assigned to physicians. The data do not reveal whether the relative absence of registered physicial therapists in one

region means that nurses are doing the work of the physical therapists, or that no rehabilitation work is being done. When a person in one occupation in fact performs a task assigned by the rules to another occupation, the substitution cannot be divined in manpower data.

There are many unfortunate results of this method of recording and the reliance placed thereon. The most important of these is that these poorly documented shifts in job content, although ubiquitous, can be ignored. Instead of support for the internal evolution of jobs with substitutions, amalgamations and revision of the older classifications for the sake of a more internally organic health care structure, the industry spawns an entirely new category of worker. This new worker, supplied with a separate designation and the sense that his job is new and different, sees himself as another line in the health care industry rather than blending with the existing structure. The process goes on like this, breeding ever-new classifications, without any more well-developed sense of internal, organizational needs.

The continual overlay of new layers of manpower with unevolved jobs but traditional training requirements and legal restrictions, is the most troublesome aspect of the development of the role of the physician assistant. A new category is not a panacea; more likely it will add to the confusion of the health care structure. It is essential that there be some thinking about the internal manpower operation with an emphasis on efficiency rather than shortage. Better and more detailed

classification and data systems would certainly be helpful in this regard but will not solve the problem without a determination to complement the strictly clinical judgment of the physician with the concern for overall efficiency and rationalization of the health planner and thereby to replace traditional boundaries with a flexible, rational system.

2. Lack of clear job definition

The second major problem of the physician assistant boom is the lack of clear thinking on the question of task allocation. This difficulty is inextricably bound up with the problem of excessive job fragmentation of the health care industry. As long as there is no understanding of the internal structure of the industry, designations of tasks can be only haphazard and arbitrary. An example of this is the California task allocation list for the physician assistant.[163] There seems to be no underlying rationale for the designations of the tasks. Instead it is a hit-or-miss approach to "giving these people something to do" without any clear sense of why or how. The Massachusetts proposal also reflects this lack of thought as to what the physician assistant will do. Depending upon the level of professional training and experience, the assistant will perform either general or specialized medical services.[164] At the time that the Board considers the application of an individual, it shall examine the particular tasks which the assistant intends to perform and determine whether or not the assistant is qualified to so function.[165] It may be wiser to allow the Board to make

such a determination on an ad hoc basis; such a system does leave room for advancement and greater responsibility in the case of more qualified individuals. However, it would also seem to be necessary to at least formulate some broad guidelines so that the medical industry and the public has a general frame of reference within which to operate.

The result of this lack of job definition is felt by both the "new" category -- the physician assistant -- as well as the "old" categories -- nurses, technicians and orderlies. The physician assistant is left without any sense of his place in the internal structure of the institution. As stated earlier, this lack does not encourage the development of professional skill and pride. As a marginal man with only a hodgepodge of tasks to call his own, the assistant is very likely to suffer from a destructive sense of anomie. There is likely to be a continuation of arbitrary jurisdictional boundaries with the assistant scrambling for his "place in the sun".

This result will probably be reinforced by the response of the existing health care categories who may be justifiably threatened by the entrance of a new category without any clear role definition. Is the physician assistant merely to rob the nurse of some of her more responsible tasks? It seems unlikely that any single task now to be assigned to the physician assistant is completely unprecedented for a nurse somewhere in the United States. This is not to imply that there are no instances when a new category is, in fact, warranted. The caveat instead

pertains to the thoughtless proliferation of job lines without definition. This can only result in a steadily increasing guardedness about jurisdictional boundaries.

B. Potential Conflict Between the Physician Assistant and Other Groups in the Health Care Structure

As a new actor in the health care industry, with its 3-1/2 million workers and its myriad types of health care workers, the physician assistant is likely to run into conflict with some of the existing groups. Although definitions do vary widely, the basic premises is that the assistant will work directly with the doctor, report directly to the doctor and will be capable of performing certain tasks now done by the doctor.[166] The two groups most likely to balk at the introduction of the assistant are the doctors and the nurses.

1. The physician and his assistant

There are two sets of problems which the physician is likely to raise in regard to the introduction of the physician assistant. The first is opposition to giving up any tasks which the physician currently and traditionally has performed; the second is a concern about potential liability for acts performed by the assistant. The first question has its roots in financial and status concerns; the second is almost wholly a financial question.

At first blush it would appear most unlikely that a physician would balk at the idea of not performing many of the more routine tasks which he currently does. It would free his time for many tasks which absolutely require his expertise and would

make it possible for him to turn his attention to more scientifically interesting material. But as with any established practice, there may be some reluctance to change. The physician may fear that the reduction in tasks will result in a reduction in control or revenue or both. The patient may question his control in the situation -- a consequence few doctors would welcome.

As long as there is a scarcity of doctors, it is unlikely that the financial pinch will be of significance. In fact, it may be possible for the physician to realize more revenue through the use of the physician assistant. More patients could be seen by the doctor; with third party payment in the form of Medicaid or Medicare guaranteed, the doctor would greatly enlarge his practice. If the day were ever to arrive when there would be a surfeit, or even a sufficiency of physicians, then there might be reason to think about the economic consequences.

Perhaps the more difficult problem to combat is the status/psychological one. The physician in this country occupies a role more than vaguely similar to the demi-god. With the help of his professional organization, the AMA, the physician has developed a very highly protected position for his profession. Traditionally, it has been well-nigh impossible to in any way attack that citadel; doctors have resisted peer review and outsiders to the profession generally do not have the necessary expertise. The introduction of the physician assistant would to some extent represent an inroad into this closed system.

The assistant is in a position to observe the physician at very close proximity. The assistant will also be performing many of the tasks formerly done only by the physician.

It is not difficult to imagine the kind of opposition which is likely to be raised. The AMA has voiced only faint approval of the introduction of the physician assistant and then only in the vaguest terms. This opposition is likely to result in an attempt to very stringently define and limit the tasks which the assistant can perform.[167] In order to combat this possibility, it is necessary to educate physicians to the needs of the population, the current inefficiencies in the health care delivery system and the possibilities for reform. Such awareness is the only tool against the guildism and fear which is likely to block change. Even if, as is likely, the educative process is not complete (or even begun?) at the time of the introduction of the physician assistant, time and experience will be a significant aid. Some work in this direction has already been started. The Association of American Medical Colleges, by action of its Council of Academic Societies, formed a Task Force on Physician's Assistant Programs in November of 1969. The Task Force was asked to consider the role of the newly developed assistants, evaluate the need for standards for programs educating them and make recommendations to the Council. The main suggestion of the Task Force was that the AAMC should promote the concept of an effective health care team by providing exposure to optimal use of assistants at the

medical school level. As a result of this study, the AAMC has become increasingly involved in the proper training, function and utilization of assistant health personnel and their acceptance in the medical world. Programs developed in the medical school, likely to expose the student to the value of the assistant, are likely to be the most fruitful approach to an education of the physician. At that stage in his professional life, the future physician is most flexible and receptive to new approaches and techniques. He is learning about his profession in general and this task method would be one part of that education. Efforts by the AAMC to develop such programs should be encouraged.

Another concern for the physician is the question of his liability for the acts performed by the assistant. If the physician is to be held fully liable for the negligence of the assistant, regardless of his own culpability, there is likely to be strong resistance on the part of the physicians. As explained earlier,[168] the traditional method has been to hold the physician vicariously liable for the negligence of any delegatee. Such a system, while insuring the public a chance for recovery in the case of negligence, is likely to have a very inhibiting effect on the role which the assistant will be permitted to assume in the health care delivery structure. The difficult policy question, therefore, is how to protect the public without dooming the chance of an effective and rational introduction of the physician assistant.

Most of the current legislation continues to hold the physician wholly liable. The result of this approach is that the new group is completely within the umbrella of the physician. This is unfortunate in terms of the group identity which the new group will be able to develop. In addition, it appears unlikely that physicians will be willing to utilize the assistant to his fullest potential under such circumstances. The wisest answer to the problem would be the development of a specific standard of care for adjudging negligence of the physician assistant coupled with encouragement for the purchase of insurance against liability. Initially the development of such a separate standard of care is likely to be a difficult task because preliminary use of the assistant will be largely experimental. Custom and practice will not be available to provide a reliable frame of reference and the courts will turn to legislative and administrative regulation. It is, therefore, essential that the administrative bodies provide clear guidelines as to the standard to which the assistant should be held.

Revision of the doctrine of respondeat superior is another step necessary to assure the doctor that he will not be held wholly liable for everything that the assistant does. A theoretical revision has been suggested earlier[169] and it seems well within the bounds of normal administrative regulations. If it is possible to effect the changes suggested so that the physician is not wholly and vicariously liable for the acts of the assistant, one of the strong fears and disincentives for the physician community will have been removed. It will be

necessary to deal with these problems so that the support of the physician can be insured.

2. The nurse and the physician assistant

Having laboriously struggled to build up a status for herself over a long period of years, the leaders of the nursing profession have resisted characterizing themselves as physician assistants or mini-doctors. This status-role conflict has been engendered in part by the desire of the nurses to establish their own standards and to retain control over their destiny. And yet, graduates of the physician assistant program at Duke University are being hired at salaries of twelve to fifteen thousand dollars per year. Nurses earn considerably less. This startling difference in salary is but one indication of the much larger problem which underlies the relationship between the nurse and the physician assistant. Today's nurse is left pondering several hard questions about her own future. Is the physician assistant to be a new category of health personnel which includes within its purview already established technical nurses supporting medical personnel? What will this changeover do to existing technical nurses? Is the fact that the person is a man or woman to make the difference between the nurse and the physician assistant?[170]

The bewilderment and hostility becomes more marked as the nurse recognizes that comparable technologies or therapeutics may be performed by the nurse as well as by the physician assistant. The key question then is not who does the work, but who

prescribes and who delegates to whom. It can be anticipated that the introduction of physician assistants into an already complicated practice relationship will intensify problems in interprofessional relationships unless congruent roles are anticipated.

a. Extension of the role of nurses

There are those who would avoid this potential clash by extending the role of nurses and obviating the necessity of introducing a new level of personnel. In 1971 a committee made up of doctors, nurses and other health-related persons including those involved in training allied health personnel, was organized to study the possibilities for extending the scope of nursing practice. Out of the meetings of this committee came a concensus that nurses could easily move into a much broader practice area and that the organized medical world, as it was represented on the committee, would have little objection.[171]

The committee broke down the role of the nurse into three discrete sections: primary care, acute care and long-term care. In each of these areas the committee found that the nurse could be playing a more significant role in the provision of services and could relieve an increasingly heavy burden on the present health care delivery system. It is significant that in each of the areas defined, the newly envisioned participation of the nurse would be almost identical with what has been vaguely hinted at for the physician assistant. In primary care, the report listed the following increase in nurse responsibilities: routine

assessment of the health status of individuals and families; screening patients having problems requiring differential medical diagnosis and therapy; institution of care during normal pregnancies, provision of family-planning services and well-baby care.[172] In the acute care area nurse responsibilities could include: securing and recording a health and developmental history and making a critical evaluation of such records; discriminating between normal and abnormal findings on physical and psychosocial assessments and reporting findings when appropriate; making prospective decisions about treatment in collaboration with physicians; initiating actions within a protocol developed by medical and nursing personnel.[173] In the long-term area, the nurse could: assess the physical status of the patient at a more sophisticated level than is now common in nursing practice; secure and maintain a medical history; conduct nurse clinics for the continuing care of selected patients; conduct community clinics for case findings and screening for health problems; assess community needs in long-term cases and participate in the development of resources to meet those needs; assume continuing responsibility for the education of patients in preventive medicine.[174]

The interface of the above extension of nursing care and the envisioned role of the physician assistant is very telling. The committee has given to the nurse many of the kinds of responsibilities which were to be within the ken of the assistant. One of the most important of these is the nurse as a leader in

community and preventive medicine. This has always been one of the particular jobs pointed out for the assistant. The nurse is also to move much more actively into a diagnostic role in the health care structure. This is particularly true in long-term care but it also seems to be part of the underlying assumptions of the changes in the three areas. The term "physician assistant" is never mentioned in the report, but one is left wondering whether the extended role of the nurse is not to be assistant as that term is currently being talked about, thereby obviating the need for any new category.

The report is very positive about the ready acceptance of this new role by the other participants in the health care structure. Actually the only group whose opinion is even considered is that of the physicians, and the committee concludes that they would welcome the revision.[175] There are only two major steps which the committee envisions as necessary before the nurse can move into her more active role. First, health education centers must undertake curricular innovations that will adequately demonstrate the physician-nurse team concept in the delivery of care. The government should make financial support available for these demonstrations as well as the development of educational programs for continuing nurse education that would prepare the nurse for her extended role.[176] Second, collaborative efforts involving schools of medicine and nursing should be encouraged to undertake programs to demonstrate effective functional interaction of physicians and nurses in the provision of health services.[177]

The reasons for the positive view of the committee members about the possibility of extension of the nursing role are in part linked to the composition of the committee. There was a rather high percentage of nurses and nursing educators in the group; doctors were the only other group which was heavily represented.[178] There were no health planners, physician assistants or others whose views might be radically different from the represented group. In addition, the committee greatly underplayed the importance of legal constraints.[179] In order to determine whether there would be any legal constraints on extending the role of the nurse, the committee prepared a list of the tasks which it had deemed that the nurse would now assume, and circulated this list to the American Nurses' Associations and State Boards of Nursing in the 53 states. These organizations were asked to give their opinion of whether there would be any legal constraints to the assumption of these tasks. Although the returns were not complete and the committee did not consider the bias of the groups it had asked, the committee accepted as gospel the comments of the respondents. Essentially, the respondents indicated that there would be no legal constraints to the committee's recommendation.[180]

Putting aside for the moment the problems of bias and statistical significance, the committee's conclusion on the unimportance of legal constraints is open to other questions. The committee relies heavily on the fact the it is the courts which will judge what is the standard of reasonable conduct for

the nurse. Nursing Practice Acts are generally vague and leave open for judicial interpretation the question of what is permitted within the bounds of that practice. Therefore, as the customary practice of the nurse to perform certain acts changes and is expanded, the courts would be very likely to interpret the statute to permit the expansion of the nurse's role.[181] It is true that the courts will be active in making these decisions and that there well may be instances when the court does permit the profession to determine what is acceptable in a given time and place. The difficulty with the reliance on this judicial role is two-fold. First, the report underestimates the disincentive effect of uncertainty. In other words, as was noted with physician delegation of tasks to allied health personnel generally,[182] one cannot know beforehand what the court's decision will be and it is likely that this uncertainty will deter even the hardiest among the nurses. In addition, one cannot be certain about the eventual outcome of the court's deliberation. Courts are essentially dispute-resolving bodies and as such work on individual cases with an emphasis on the fact pattern before it. The court is not the appropriate body to ask for policy decisions based on overviews of health care needs. Decisions are likely to be erratic and controlled by the particular fact pattern and the particular judge making the decision. There can be no certainty, therefore, about the outcome of the cases and such reliance on a strictly consistent judicial stance seems misplaced. Judicial interpretation is always

chancy business; these uncertainties are not noted by the report.

The recommendations of the committee are important in pointing out that there is an alternative to the current emphasis on the introduction of the physician assistant. It highlights the unfortunate fact that it is easier to create a new job than to rethink, revise and update the training or certification of an old one. Nurses are concerned about the results of introducing the physician assistant, have reason to be so, and are likely to do as much as they can to resist the change or, at least, insist on a very clear definition of role.[183] The report of the committee, however, while a useful reminder of this resistance and concern, does not go much beyond that in instructiveness because it blithely assumes away the major policy problems contained within extending the scope of the nurse's role.

b. Some attempt at conciliation

The problem of the relationship between the nurse and the physician assistant has been noted but not resolved. Ardent supporters of the new group are concerned lest opposition from the nurses doom the movement to credential the physician assistant. Attempts are being made to assure the nurses that advances for them are not precluded by the introduction of the physician assistant nor that nurses will have to become physician assistants in order to benefit from any change.

An important recent development in the nursing profession is the "nurse-practitioner" or the "nurse-clinician." Essentially this represents an extension of the role of the registered nurse in the primary health care setting with an emphasis on preventive

medicine and community health programs. At the recent legislative hearings at the Massachusetts State House,[184] many of the proponents of the Massachusetts credentialling legislation made careful reference to this development in the nursing profession in an attempt to head off opposition from the nurses. Thus, the statement of the Governor's Advisory Council to the Office of Comprehensive Health Planning included within its recommendation that the introduction of the physician assistant in no way impede the development and functioning of the "nurse-practitioner."[185]

Regardless of the shortcomings of the committee report mentioned earlier, planners would be well-advised to consider the expansion of the scope of nursing as an alternative to the introduction of the physician assistant. At the very least, a complementary relationship could be developed so that the existing group could continue to play an active and developing role in the health care delivery system. It may be that, at the present time, the more feasible alternative in terms of public acceptance and legislative action, is the introduction of a new classification of personnel. But such political expediency should not be permitted to overshadow the contribution which nurses can and want to make to a more efficient and accessible health delivery system.

VI. CONCLUSION: CONFLICTS AND TRADEOFFS

There is much positive discussion these days about the introduction of a new classification of intermediate health care personnel in order to improve the health care delivery system. Such a group could provide more medical services and also serve other positive goals of efficiency, the provision of jobs for minority groups and more accessible health care services. Credentialling legislation has already been passed in California, and Massachusetts is currently in the throes of reaching a decision about a similar proposal.

There remains the question of what kind of legislation would be most suitable to credential the physician assistant. The choice must depend upon weighing the constraints that exist among the alternatives. The following basic question must be asked: Is the option so promising and viable as to warrant the steps necessary to overcome the constraints that exist? The constraints may be divided into five groups: administrative, financial, time, legal or constitutional, and political or institutional constraints.

Administrative constraints. Does the option require establishment of criteria that may be difficult to define for general application? Does it require unreasonable numbers of qualified persons for administration and surveillance? Does it make more complex the current multiplicity of jurisdictions governing health services?

Financial constraints. Does the option impose excessive financial costs for administration and surveillance? For retraining personnel? For malpractice insurance coverage?

Time constraints. Is the option sufficiently developed and tested to be implemented with adequate speed? Is a demonstration or trial period warranted?

Legal or constitutional constraints. Is the option within the purview of the state or federal government? How does it affect the possibility of lawsuits and disciplinary actions against health workers? Does it substitute rigid new laws for current inflexible controls?

Political or institutional constraints. Is the option politically realistic and feasible in light of vested interests of professional and occupational groups? Is it based on an awareness of practices of institutions and facilities? Is it contrary to professional attitudes that inhibit changed use of personnel? Does it recognize pressures from the community and unions for employment and upward mobility of auxiliary workers? Does it comply with the current demand for consumer participation in the delivery of health care?

The first option to be considered is that no legislation is needed and that the courts should frame the suitable position for the physician assistant in a case-by-case method. This option is not at all viable because the courts are not the appropriate institution to be shaping such broad public policy and because the continued existence of potential liability for the physician.

and his assistant would severely limit the development and utilization of the physician assistant.

A second alternative is to amend the medical practice acts to authorize broadened delegation of functions as has been done in Arizona, Colorado, Kansas and Oklahoma. The Oklahoma statute, for example, authorizes service by a "physician's trained assistant. . .if such service be rendered under the direct supervision and control of a licensed physician.[186] Such a provision may provide increased protection against liability, but it gives statutory sanction to only those functions already adopted in custom and practice. This is an essentially static situation and innovative use of personnel would still be inhibited.

A national licensing examination or system of accreditation would eliminate barriers to geographic mobility. These options would also contribute to improved quality of personnel. The strongest barrier to the enactment of such national legislation is that it would wrest so much power from the states. In these days when the trend seems to be so much in favor of less power for the central government and more power and responsibility for the states, it appears to be highly unlikely that such an alternative has much potential.

Within the framework of state government, two options present themselves: a separate licensure provision for the physician assistant or the establishment of a statewide committee or board to regulate innovations in using allied and auxiliary personnel. The former option is at variance with the need for optimal and

innovative use of health personnel. It would accentuate and perpetuate the existing fragmentation of functions. The licensure of yet another category of personnel would only serve to further harden current rigidities of the system. On the other hand, the establishment of a statewide board to regulate the functions and education of the physician assistants does meet the need for authorizing innovations in the use of personnel. This option encounters administrative constraints related to the drafting of guidelines for the physician assistant. As has been demonstrated in California, it is only too easy for the board to severely constrict the assistant. Nonetheless, the experience in that state did indicate that the existence of strong opposition to such rigid definitions can successfully counter the board. If the board is well-constructed, i.e., sufficient representation to diverse and knowledgeable groups rather than exclusive domination by the physicians, there exists the possibility that the approach of the board can be both careful and flexible. Varied representation on the board can also dampen political opposition.

In spite of its potential drawbacks, the development of such a statewide credentialling board seems to be the most promising alternative. It would not rigidly constrict the work to be done by the physician assistant. The board could evolve over time a system of regulation sufficiently flexible to take account of new health needs, new knowledge and changed technological and social conditions in health services. Moreover, the supervision

of the board would be some assurance of protection of the public. The legal constraints currently inhibiting the development of the physician assistant would be overcome if the doctrine of respondeat superior were modified and the physician assistants were encouraged to purchase malpractice insurance of their own. At the present time, the political climate for the introduction of the assistant via such boards seems favorable. In a short time consideration can be given to the actual functioning of such a board in both California and, hopefully, Massachusetts. The examination of that data will be the most revealing barometer of all.

FOOTNOTES

1. Act of October 30, 1972, Pub. L. No. 92-603 (41 USLW 107), amending 42 U.S.C. §1395 (Supp. V, 1970).

2. The statute read as follows:

> (a)(1) The Secretary of Health, Education and Welfare is authorized, either directly or through grants to public or nonprofit private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects for the following purposes:
>
> (G) to determine under what circumstances payment for services would be appropriate and the most appropriate, equitable, and noninflationary methods and amounts of reimbursement under health care programs established by the Social Security Act for services, which are performed independently by an assistant to a physician, including a nurse practitioner (whether or not performed in the office of or at a place at which such physician is physically present), and --
>
> (i) which such assistant is legally authorized to perform by the State or political subdivision wherein such services are performed, and
>
> (ii) for which such physician assumes full legal and ethical responsibility as to the necessity, propriety, and quality thereof.

Act of October 30, 1972, Pub. L. No. 92-603, §222(b)(1) (41 USLW at 127-28), amending 42 U.S.C. §1395b-1(a).

3. The preface reads as follows:

> The Secretary of Health, Education, and Welfare, directly or through contracts with, or grants to, public or private agencies or organization, shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of various alternative methods of making payment on a prospective basis to hospitals, skilled nursing facilities, and other providers of services for care and services provided by them under title XVIII of the Social Security Act and under State plans approved under titles XIX and V of such Act, including

alternative methods for classifying providers, for establishing prospective rates of payment, and for implementing on a gradual, selective, or other basis the establishment of a prospective payment system, in order to stimulate such providers through positive (or negative) financial incentives to use their facilities and personnel more efficiently and thereby to reduce the total costs of the health programs involved without adversely affecting the quality of services by containing or lowering the rate of increase in provider costs that has been and is being experienced under the existing system of retroactive cost reimbursement. (Emphasis added.)

Act of October 30, 1972, Pub. L. No. 92-603, §222(a)(1). (41 USLW at 127).

4. See Part V, §B, infra.

5. See Part III, §B(5), infra.

6. See Part III, §B(2), infra.

7. See Part II, §C(4), infra.

8. See Part II, §C(4)(c), infra.

9. See Part IV, §§C, D, infra.

10. Towards a Comprehensive Health Policy for the 1970's, U. S. Department of Health, Education and Welfare (Washington: U. S. Govt. Printing Office, 1971), p. 5.

11. Ibid.

12. "The Distribution of Physicians by Census Tract, Boston and Brookline", Joseph Dorsey, M.D. (unpublished master's thesis, Yale U. Sch. of Public Health, 1968), as cited in Gerald Rosenthal, "Health Care", The State and the Poor, ed. Samuel Beer and Richard Barringer (Cambridge: Winthrop Publishers, 1970), p. 207.

13. Towards a Comprehensive Health Policy for the 1970's, p. 14.

14. Herbert Klarman, The Economics of Health (New York: Columbia U. Press, 1965), p. 100.

15. Relationship between income and having a physician.

Family income	# of families	% of families having a physician
welfare	621	16
less than $3,000	333	24
$3,000-$4,500	1,369	38
$4,500-$6,000	1,009	55
$6,000-$7,500	452	62
$7,500-$10,000	191	63
more than $10,000	75	86

Source: Joel J. Alpert, et. al., "Types of Families That Use an Emergency Clinic", Medical Care, 7 (Jan.-Feb. 1969) p. 15.

16. Towards a Comprehensive Health Policy for the 1970's, p. 15.

17. The proportion of all physicians in private practice fell from 73 per cent in 1950, to 65 per cent in 1960, to 63 per cent in 1965. Health Resources Statistics, 1965, U.S. Dept. of Health, Education and Welfare (Washington: National Center for Health Statistics, 1966), p. 102.

18. Towards a Comprehensive Health Policy for the 1970's, p. 21.

19. Rashi Fein, The Doctor Shortage, (Washington, D.C.: The Brookings Institute, 1967), p. 60.

20. Title XVIII of the Social Security Act, 42 U.S.C. §1395 (Supp. V, 1970).

21. 42 U.S.C. §1395i.

22. Id., §1395c.

23. Towards a Comprehensive Health Policy for the 1970's, p. 13.

24. 42 U.S.C. §1396a(a)(10)(B)(II) (Supp. V, 1970).

25. Title XIX of the Social Security Act, 42 U.S.C. §1396 (Supp. V, 1970).

26. 42 U.S.C. §301 (1964).

27. 1965 U.S. Code & Ad. News 2014.

28. 1967 U.S. Code & Ad. News 3021.

29. Cong. Rec. 6 (daily ed. Jan. 25, 1971) (Health Security Act §2b(1)) [hereinafter cited as Kennedy Bill].

30. National Health Insurance Partnership Act of 1971, H.R. Doc. No. 7741, 92d Cong., 1st Sess. §600(b) [hereinafter cited as Nixon Bill].

31. 117 Cong. Rec. 3 (daily ed. April 5, 1971) (National Health Care Act, Introduction) [hereinafter cited as McIntyre Bill].

32. 458 F.2d 1115 (10th Cir. 1972).

33. 42 U.S.C. §291 (Supp. V, 1970).

34. 458 F.2d at 1117.

35. Id. at 1118.

36. 42 U.S.C. §1395 (Supp. V, 1970).

37. The effect (at least partially) of this unrestrained use has been a steady increase in medical care prices. Between 1960 and 1970, medical care prices rose far more rapidly than prices in general. Hospital charges rose four times as fast as other items in the Consumer Price Index, and physicians' fees at twice the rate. Towards a Comprehensive Health Policy for the 1970's, p. 22.

38. Rosenthal, pp. 208-209.

39. Towards a Comprehensive Health Policy for the 1970's, pp. 31-36. The emphasis on neighborhood health centers is also evidenced by the frequent reference in the proposed national health insurance schemes to the establishment of such centers. The McIntyre Bill calls for the development of comprehensive ambulatory health care centers and requires the development of training programs for new levels of health professions to staff these cneters. McIntyre Bill §203(b)(2). The Kennedy proposal provides grants for the creation and enlargement of organizations in the urban environment which can provide health services to an ambulatory population. Here again, grants are to be available for the training of new kinds of health personnel to assist in providing comprehensive services on the neighborhood level. Kennedy Bill, §§47, 104. The popularity of the neighborhood health care center is attested to by the rapid increase in their number, in the last few years. In Boston, for example, 24 centers were operating as of October 1970 and several more were in the planning stages. Boston Globe, October 11, 1970,

p. 6. Less than one year later, 37 centers were operating in the city. A Directory of Boston Neighborhood Health Centers, Action for Boston Community Development, Inc., 1971

40. The Joint Council of National Pediatric Societies, for example, has stated that 75 percent of the pediatric tasks performed by a physician could be done by a properly trained child health assistant. Towards a Comprehensive Health Policy for the 1970's, p. 11.

41. Rashi Fein, The Doctor Shortage (Washington: The Brookings Institute, 1967), p. 116.

42. Eleanor Lambertsen, "Not Quite M.D., More Than P.A.", Hospitals, vol. 45 (December 1, 1971), p. 71.

43. Ibid., p. 76.

44. Harold Goldstein and Morris Horowitz, Restructuring Paramedical Occupations, Manpower Admin., Dept. of Labor (Washington: U.S. Govt. Printing Office, 1972), p. 52.

45. Ibid., p. 5.

46. For background on this subject, see Goldstein and Horowitz, pp. 25-28.

47. Ibid., p. 16.

48. For a complete description of the agonizing and arduous procedure, see ibid., pp. 29-44.

49. The hierarchy was set out in this way:

Group A: Nurse's aide
Orderly

Group B: Licensed practical nurse

Group C: Registered nurse
Head nurse
Nurse supervisor
Director of nursing

Group D: Intern
Resident
Chief of medicine

There is no upward mobility between groups. Ibid., pp. 4-5.

50. Ibid., p. 52.

51. Ibid., p. 72. Note that the training for each of these categories was to be provided through in-service training.

52. The requirements were modified in 1971. Ibid., p. 8.

53. Ibid.

54. Ibid.

55. M. Y. Pennel and D. B. Hoover, Health Manpower Source Book, Allied Health Manpower Supply and Requirements: 1950-80 (Washington: U. S. Govt. Printing Office, 1970).

56. A. Robbins, "Allied Health Manpower - Solution or Problem?" The New England Journal of Medicine, vol. 286, no. 17 (April 27, 1972), p. 919.

57. Ibid., p. 920.

58. Goldstein and Horowitz, pp. 25-28.

59. Nebbia v. New York, 291 U.S. 502 (1934).

60. Forgotson and Cook, "Innovations and Experiments in Use of Health Manpower - The Effect of Licensure Laws," Laws and Contemporary Problems, vol. 32 (1967), p. 735.

61. Ibid., pp. 740-742.

62. Mass. Gen. Laws c. 112, §9a (1971).

63. American Medical News, April 20, 1970, p. 1.

64. See, e.g., Lee v. Calvert, 215 Md. 457, 138 A.2d 902 (1958); Moeller v. Hauser, 237 Minn. 368, 54 N.W.2d 639 (1952).

65. F. Harper and F. James, The Law of Torts (Boston: Little, Brown & Co., 1956), II, §26.6.

66. 68 Wash. 2d 139, 411 P.2d 861 (1966).

67. Anderson, Licensure of Paramedical Personnel, p. 6. Address before 65th Annual Meeting of the Federation of State Medical Boards of the United States, February 7, 1969.

68. 57 Cal.2d 74, 366 P.2d 816, 17 Cal Rptr. 488 (1961).

69. Id. at 82-83, 366 P.2d at 819, 17 Cal. Rptr. at 491.

70. Id. at 84-85, 366 P.2d at 820-821, 17 Cal. Rptr. at 492-493.

71. Civil No. 35307, Justice Court of Redding Judicial District (Shasta County, Cal., Dec. 1966), petition dismissed, 438 P.2d 358, 66 Cal. Rptr. 710 (1968).

72. Record at 861. [emphasis added].

73. See note 65 and accompanying text supra.

74. In Thompson v. Brent, 245 So.2d 751 (4th Cir. 1971), plaintiff-patient filed suit against defendants physician and medical assistant for injuries sustained while under the doctor's treatment. The court found both liable. There were two important holdings in the case which illustrate the strict liability of the physician: first, the medical assistant was held to the standard of care of a physician; second, despite the fact that there was no claim that the doctor had been negligent, he was held liable for the negligent (as defined by the standard of care previously mentioned) acts of an employee while engaged in the course and scope of employment. Such findings are obviously a strong deterrent to the use of allied health personnel. See also, Mazer v. Lipshutz, 31 F.R. 123 (E.D. Pa. 1962); Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960); McElroy v. Employers' Liability Assurance Corp., 163 F. Supp. 193 (W.D. Ark. 1958); Thompson v. Lillehei, 164 F. Supp. 716 (D. Minn. 1958); Stone v. Sisters of Charity, 2 Wash. App. 607, 469 P.2d 229 (1970).

75. W. Prosser, Law of Torts (3rd ed., St. Paul, Minn.: West Publishing Co., 1964), §35, p. 202.

76. Hendry v. United States, 418 F.2d 774, 784 (2d Cir. 1969); see Annot., 19 A.L.R. 2d 1188, 1204-1206 (1951).

77. See notes 68 and 71 supra.

78. The fact that the physician carries malpractice insurance will usually not mitigate the financial results of such a suit. Today, malpractice policies generally carry a provision explicitly excluding "injury arising out of the performance of an illegal act." See D. Louisell and H. Williams, Trial of Medical Malpractice Cases, §20.04 (1969). Under such a provision it might be that the delegation to an unlicensed paramedical was an "illegal act" and thus excluded from coverage of the policy.

79. See note 72 and accompanying text supra.

80. See Board of Medical Examiners v. Gardner, 201 N.C. 123, 159 S.E. 8 (1931).

81. Occupational therapy personnel have been registered for the past forty years by their own professional organization. The Occupational Therapy and American Occupational Therapy Association sets its own standards and these standards have been accepted by employers. It is an excellent example of an Association-administered certification plan. Florence S. Cromwell, Report at the Panel Discussion on Occupational Barriers, Health Manpower: Adapting in the Seventies, Report of the 1971 National Health Forum (New York: National Health Council, 1971), pp. 104-109.

82. Milton Friedman, Capitalism and Freedom (Chicago: University of Chicago Press, 1962), pp. 144-145.

83. E. H. Forgotson, R. Roemer, and R. W. Newman, "Legal Regulation of Health Personnel in the United States," Report of the National Advisory Commission on Health Manpower (Washington: U. S. Govt. Printing Office, 1967), pp. 292-294, 423-428.

84. Department of Community Health Sciences, Model Legislation Project for Physician's Assistants (Durham: Duke University Press, 1970), p. 11. Legal counsel relied on the Magit opinion. See notes 68-70 supra.

85. Ibid.

86. See Part II, §C, 4(a) supra.

87. See notes 66-70 and accompanying text supra.

88. See Ariz. Rev. Stat. Ann. §32-1421(6) (Supp. 1970; Colo. Rev. Stat. §91-1-6(3)(m) (1963); Kan. Stat. Ann. §65-2872(g) (1964); Okla. Stat. Ann. tit. 59, §492 (Supp. 1970).

89. See note 88 supra.

90. Colo. Rev. Stat. §90-10-1 (1969).

91. If the statute specifies only one subprofessional group for permissible delegation, then, by strict statutory construction, all others are excluded.

92. Cal. Bus. & Prof. Code §§2510-22 (West Supp. 1971).

93. See note 82 and accompanying text supra.

94. Commonwealth of Massachusetts, House Bill 3730, amending Mass. Gen. Laws c. 112, §9 (1973). A bill was introduced last year which would have served a very similar function to that which is served by the current legislation. Commonwealth of Massachusetts, House Bill 4999, amending Mass. Gen. Laws c. 112, §9 (1972). The earlier bill was not passed; instead it was placed under a study order and reintroduced this year. Commonwealth of Massachusetts, Study Order, House of Representatives No. 5871, May 17, 1972.

95. Commonwealth of Massachusetts, House Bill 3730, amending Mass. Gen. Laws c. 112, §9 (1973), noted as §9F.

96. Id., §9G.

97. Id.

98. Id.

99. Id., §9E(e).

100. Id., §9G.

101. Id., §9E.

102. Id. Contrast this with the corresponding silence in the California plan.

103. In Shapiro v. Thompson, 394 U.S. 618 (1969), the Court held that a Connecticut residency requirement for welfare payments was violative of the Equal Protection Clause. Justice Brennan used the higher standard of review for a fundamental interest because the state statute affected the constitutionally protected right to interstate travel. Id. at 630. Query whether such a Shapiro argument could be raised as a constitutional objection to state licensure laws.

104. Kennedy Bill, §105(h).

105. 291 U.S. 502 (1934).

106. Id. at 510.

107. Barsky v. Board of Regents, 347 U.S. 442, 449 (1954).

108. Dent v. West Virginia, 129 U.S. 114 (1889).

109. 317 U.S. 111 (1942).

110. Id. at 125.

111. 379 U.S. 294 (1964).

112. Id. at 297.

113. Id. at 302, quoting from Gibbons v. Ogden, 9 Wheat. 1, 195 (1824).

114. 379 U.S. at 303-304.

115. H. Hart and H. Wechsler, The Federal Courts and the Federal System (Brooklyn: Foundation Press, 1953), pp. 435-436.

116. Huron Portland Cement v. City of Detroit, 362 U.S. 440, 443 (1960).

117. Id. at 444. For example of state power yielding to federal legislation in the health area see Catholic Med. Center of Brooklyn & Queens, Inc. v. Rockefeller, 305 F. Supp. 1268 (D.C. N.Y. 1969).

118. U.S. Civil Service Commission, Bridging the Medical Care Gap, the Physician's Assistant, Announcement No. 428 (1971).

119. Ibid., p. 3.

120. Ibid., p. 4. Note that these are the minimal requirements for a GS-7 rating. If additional education or experience is present, the candidate may receive a GS-9 or GS-11 rating.

121. See text on Supremacy Clause, notes 116 & 117 and accompanying text, supra.

122. Report of the National Advisory Commission on Health Manpower, vol. 1 (Washington: U.S. Govt. Printing Office, 1967), p. 42.

123. National Committee for Careers in Medical Technology, Interdisciplinary Groups Plan Proficiency Examinations (Bethesda, Md.: Department of Health, Education and Welfare, 1970), Gist. No. 48, pp. 1-3.

124. National Committee for Careers in Medical Technology, Equivalency and Proficiency Testing Related to the Medical Laboratory Field (Bethesda, Md.: Department of Health, Education and Welfare, 1970).

125. For one breakdown of the models, see National Academy of Sciences, New Members of the Physician's Health Team: Physician's Assistants (1970), pp. 3-4.

126. See note 88 supra.

127. See notes 90 & 91 and accompanying text supra.

128. The question of whether such a delegation is an impermissible delegation of power by the legislature (particularly on the state level) is one which has crossed this writer's mind but has not been explored.

129. Cal. Bus. & Prof. Code §§2516-17 (West Supp. 1971).

130. Id. at §2101.

131. See Massachusetts proposal discussed in Part III, §C(4) supra.

132. Under the California scheme, the prospective physician-employer nominates an individual to the Board. Each application must include the qualifications of the paramedic, background of the physician and the description of the way in which the paramedic will be used. Cal. Bus. & Prof. Code §§2516-17 (West Supp. 1971).

133. For one thing, administrative agencies have seldom used their power to promulgate rules and regulations in order to clarify the statutory scope of practice definition. See, e.g., Cal. Ad. Reg. tit. 16, c. 14 (1966).

134. See Part IV, §E, infra.

135. See notes 63-76 and accompanying text supra.

136. This was obviously noted by the drafters of the Kennedy National Health Insurance scheme. As a result, the bill contains instructions to the Secretary of Health, Education and Welfare to conduct a comprehensive study of all aspects of malpractice in order to determine the relationship between such litigation and the use of health manpower. Kennedy Bill, §404(b)(3).

137. See note 88 supra.

138. See note 92 and accompanying text supra.

139. See text at Part IV, §B supra.

140. Note, "Paramedics and the Medical Manpower Shortage: The Case for Statutory Legitimization," Georgetown Law Journal, vol. 60 (1971), pp. 171-172.

141. Such a rationale would merely be another application of a line of thinking already developed. See, e.g., Hallinan v. Prindle, 17 Cal. App. 2d 656, 62 P.2d 1075 (1936) (nurse who had acted negligently in her professional role was solely and personally liable for injury to the patient.)

142. Statutes like the California program would lend weight to the physician assistant's professional standing.

143. This has been done in a variety of instances. See, Norton v. Argonaut Ins. Co., 144 So. 2d 249, 260 (La. App. 1962) (nurses); Rush v. Akron Gen. Hosp., 85 Ohio L. Abs. 292, 295, 171 N.E.2d 378, 381 (Ct. App. 1957) (nurses).

144. See Restatement (Second) of Torts, §285, comment b (1965).

145. See text accompanying notes 92-93 supra.

146. "Notice of Proposed Regulations of the Board of Medical Examiners of the State of California" (Board of Medical Examiners, California, October 1971) (mimeo).

147. State of California, Regulations of the Physician's Assistant Examining Committee of the Board of Medical Examiners, Department of Consumer Affairs, Feb. 1972, c. 13, art. 15.

148. "Notice of Proposed Regulations of the Board of Medical Examiners of the State of California", p. 7.

149. Regulations of the Physician's Assistant Examining Committee of the Board of Medical Examiners, §1379.24(a).

150. Ibid., §1379.25.

151. Ibid.

152. Ibid., §1379.24(e).

153. See note 156 infra.

154. Regulations of the Physician's Assistant Examining Committee of the Board of Medical Examiners, §1379.24(l).

155. Ibid., §1379.23.

156. "Specifically and by way of limitation, an Assistant to the Primary Care Physician should be able to:

"(a) Take a complete, detailed and accurate history; perform a complete physical examination, when appropriate,

excluding pelvic and endoscopic examination; and record and present pertinent data in a manner meaningful to the Primary Care Physician.

"(b) Perform and/or assist in the performance of the following routine laboratory and screening techniques:

1. The drawing of venous blood and the routine examination of the blood.
2. Catheterization and the routine urinalysis.
3. Nasogastric intubation and gastric lavage.
4. The collection of and the examination of the stool.
5. The taking of cultures.
6. The performance and reading of skin tests.
7. The performance of pulmonary function tests excluding endoscopic procedures.
8. The performance of tonometry.
9. The performance of audiometry.
10. The taking of EKG tracings.

"(c) Perform the following routine therapeutic procedures:

1. Injections.
2. Immunizations.
3. Debridement, suture and care of superficial wounds.
4. Debridement of minor superficial burns.
5. Removal of foreign bodies from the skin.
6. Removal of sutures.
7. Removal of impacted cerumen.
8. Subcutaneous local anesthesia, excluding any nerve blocks.
9. Anterior nasal packing for epistaxis.
10. Strapping, casting and splinting of sprains.
11. Removal of casts.
12. Application of traction.
13. Application of physical therapy modalities.
14. Incision and drainage of superficial skin infections.

"(d) Recognize and evaluate situations which call for immediate attention of the Primary Care Physician and institute, when necessary, treatment procedures essential for the life of the patient.

"(e) Instruct and counsel patients regarding matters pertaining to their physical and mental health, such as diets, social habits, family planning, normal growth and development, aging, and understanding of, and long-term management of their disease.

"(f) Assist the Primary Care Physician in the hospital setting by arranging hospital admissions under the immediate direction of said physician; by accompanying the Primary Care Physician in his rounds and recording physician's patient progress notes; by accurately and appropriately transcribing and/or executing specific orders at the direction of the Primary Care Physician; by compiling and recording detailed narrative case summaries; by completing forms pertinent to the patient's medical record."

Ibid., §1379.23(a)-(f).

157. Ibid., §1379.22.

158. "Notice of Proposed Regulations of the Board of Medical Examiners of the State of California", 2.

159. Regulations of the Physician's Assistant Examining Committee of the Board of Medical Examiners, §1379.22.

160. This is particularly true when one considers the rather limited repertoire the assistant is going to be allowed. Ibid., §1379.23(a)-(f).

161. Cal. Bus. & Prof. Code §2515(b) (West Supp. 1971).

162. See note 55 and accompanying text supra.

163. See note 156 supra.

164. Commonwealth of Massachusetts, House Bill 3730, amending Mass. Gen. Laws c. 112, §9(E).

165. Id., §9G.

166. In the Cambridge City Hospital study, for example, it was specifically recommended that the physicians' assistant be under the direct control of the medical staff and explicitly divorced from the nursing division. Goldstein and Horowitz, p. 71.

167. An example of this kind of restriction is found in the proposed 1973 Massachusetts legislation. In defining the tasks which the assistant may perform, the act provides that:

"No medical services may be performed under this article in any of the following areas:

"(a) The measurement of the powers of range of human vision, or the determination of the accommodation and refractive states of the human eye or the scope of its function in general, or the fitting or adaptation of lenses or frames for the aid thereof.
"(b) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training or orthoptics.
"(c) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to the human eye.
"(d) The practice of dentistry of dental hygiene as defined in chapter 112 sections 50 and 51.
"(e) The practice of manipulative therapy of chiropractic. Nothing in this section shall preclude the performance of routing visual screening."

Commonwealth of Massachusetts, House Bill 3730, amending Mass. Gen. Laws c. 112, §9 (1973), noted as §9E.

168. See Part II, §C(3) supra.

169. See Part IV, §D supra.

170. Lambertsen, Hospitals, 45, 76.

171. Extending the Scope of Nursing Practice, A Report of the Secretary's Committee to Study Extended Roles for Nurses (Washington: U.S. Govt. Printing Office, 1971).

172. Ibid., p. 9.

173. Ibid., p. 10.

174. Ibid., pp. 11-12.

175. Ibid., p. 7.

176. Ibid., p. 6.

177. Ibid., p. 7.

178. Ibid., p. i.

179. Part of this minimization may be due to the fact that there was not one lawyer on the committee. The only legal advice the committee received was that solicited from the American Nursing Associations and State Board of Nursing. Ibid., p. 12.

180. Ibid., pp. 12-14.

181. Ibid., p. 13.

182. See Part II, §C(4) supra.

183. Lambertsen, Hospitals, p. 45. "Position Statement on the Physician's Assistant", Massachusetts Nurse Association (mimeo).

184. Hearings on House Bill 3730 Before the Joint Social Welfare Committee, March 14, 1973.

185. Testimony of Dorothy Garrison for the Governor's Advisory Council to the Office of Comprehensive Health Planning, March 14, 1973.

186. Okla. Stat., tit. 59 §492 (Supp. 1966).