Editorial:  
FRAGMENTATION OF WORKERS: AN ANTI-PERSONNEL WEAPON

One of Health-PAC's most familiar themes is that the industrial revolution has at last come to the field of health care. No longer is medicine a cottage industry practiced by individual doctors; no longer are hospitals remote deathhouses for the poor. Indeed, more than ever health care has become centered in large institutions manned by thousands of workers and replete with increasingly complex technology. The last twenty years have seen the hospital workforce triple and the use of hospital equipment quadruple. Not surprisingly, corporate management and conglomerate organization now set the trend in health care delivery.

This BULLETIN examines yet another aspect of the growing industrialization of health care—what it means for the millions who work in these health care factories. Here we see some familiar historical parallels. The growth of new technology and the need for mass production have created new and more specialized categories of work. In their need for decent wages and job security, hospital workers, who are among the lowest paid in the entire workforce, have begun to organize. Some, particularly those in the lower echelons, have gone the route of unionization (see BULLETIN, July-August, 1970). Others, particularly those doing the increasingly specialized tasks, have sought the same ends through professionalization—organizing to claim control of the particular tasks by forming associations which certify members, establish entry requirements, and seek to codify their functions into state law. Since the turn of the century, the "allied health professions" have proliferated tenfold until there are now some 125 recognized health occupations and 250 secondary or specialist designations.

These new health professions follow in the path of their grand predecessor: the doctors and their protective association, the American Medical Association (AMA). There is one major difference, however: each new profession starts with successively less of the turf. Each seizes what it can in terms of power and territory without encroaching on that of the more established and powerful professions, and then joins them in jealously guarding the borders of the new status quo. In fact, most of the emerging health professions are under the indirect control of the AMA and, on the job, the doctors themselves. The differences in power and prestige between the AMA and some of the newcomers are so great that often their only similarity is the claim to professional status.

What does this mean for workers? For those on the inside, professional status does assure some degree of job security, status and higher wages, but at the expense of reinforcing the monotonous, fragmented, alienating nature of the work and rigidifying the job hierarchy within
hospitals. For example, the educational requirements thrown up to guard entry to a profession often lock its members into dead-ended, assembly-line-like jobs. For those on the outside, the entry requirements often act to establish the profession as the domain of a particular sex, race or class of workers.

In many respects the development of the allied health professions echoes that of the craft unions of the old AF of L which organized on the basis of particular skills and, in so doing, set worker against worker, skill against skill and the skilled against the lesser-skilled. And among hospital workers we already see the nurse practitioner vying with the physician assistant and the research technician with the lab technician for crumbs of status, autonomy, and upward mobility, rather than focusing on those who set the context and conditions of hospital employment.

But even for the administrators and doctors who run the hospitals, the profusion of professions has gotten out of hand. Not only has it created chaos in job categories, training programs, and recruitment, but more importantly to them, it has run up labor costs. Hence, "efficiency" and "rationalization" have become the words of the day. To achieve these, hospitals would use institutional licensure, binding workers to the institution for their license or certification, as well as for their jobs.

However, the power of the large professional associations makes such a move clearly unrealistic for the time being. So instead, to halt the chaos while they plot a final solution, the hospitals are moving for a two-year moratorium on licensing. And for this, they have the support of the powerful professional associations which, having gotten theirs, don't mind slopping down the yet unorganized workers who would attempt to follow in their footsteps.

Because the historical parallels are abundant, one would hope that hospital workers might benefit from the rich experience of other industrial workers. Time and again it has been shown that when workers seize on the small bits of privilege which distinguish them from other workers, rather than focusing on the vast majority of conditions which unite them, only management wins. And likewise it has become clear that while decent wages and job security are necessary, they are not sufficient. For hospital workers, perhaps even more than others, it is essential that issues such as job mobility, breaking down the hierarchy, job satisfaction, working conditions and other issues are addressed which might bring an end to the alienation from work.

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I certify that the statements made by me above are correct and complete. (signed) Ronda Kotelchuck, managing editor.
Licensure, the point at which government steps in to protect the interests of health professional groups, has traditionally been justified as necessary to protect the public from quackery and to ensure quality of care. Workers' groups have seized upon licensure as a means of increasing salaries and ensuring job security. In the last 25 years, as a response to the phenomenal development of medical technology and the increasing demand for services, new categories of workers have proliferated. Tensions have developed among new and old groups of workers as each attempts to guard its set of skills from further encroachment. But the number of "professions" has skyrocketed so that there are now 375 sometimes overlapping job categories each vying for professional status. The result is chaos in the health work force.

History: Monopoly Legalized

Licensing is merely the final stage in the progression that workers follow in their search for protection. The process is always the same: Technology or increased demand creates a new task and a need for on-the-job training. This eventually produces a job category and an identifiable group of workers who form an association in their search for economic security. The association certifies its members, establishes educational criteria, lobbies and propagandizes for state licensing. Finally, educational and experiential criteria are codified into state law and a state board is created, which is usually composed of members of the association.

This pattern was first established by doctors and the American Medical Association (AMA), organized in 1847. While there had been some medical licensing earlier, all laws had been repealed around 1830, as healing sects appeared and it became increasingly difficult to judge their relative worths. Regardless of their quality or lack thereof, the expansion of cults like Thompsonism, eclecticism, and homoeopathy, and the proliferation of schools which provided easy access to the medical profession, meant that women, the poor, and members of minority groups could practice the healing arts. Severe economic competition, coupled with a desire to establish control over their profession, led the emerging AMA to challenge the credibility and power of the schools and cults.

The parallel expansion of scientific knowledge in Western Europe provided the AMA with its ammunition. In 1893 the first European-style, scientifically-oriented medical school in the United States was set up at Johns Hopkins. Claims of expertise based on real medical advances, coupled with sometimes valid charges of quackery levelled at sects who lacked the resources to cash in on the new science, gave doctors pre-eminence in the eyes of lawmakers and the public. Consequently,
between 1881 and 1900 almost all states enacted licensing laws for physicians. The influence of the doctors was further strengthened by the influx of enormous sums of money from philanthropic foundations set up by Nineteenth Century robber barons. After successfully courting their well-to-do clientele for many years, physicians, now almost entirely white, male, and middle class, became the beneficiaries of this new source of income. Starting in 1903, foundations began to pour money into four-year medical schools, which were patterned on the European-Hopkins model. In 1904 the AMA created its Council on Medical Education (CME) to accredit schools and guarantee that control of medical education would never again slip away. The CME immediately sponsored a study of medical schools conducted by Abraham Flexner, a member of the staff of the Carnegie Foundation. In 1910 the influential Flexner Report was issued, extolling the virtues of the Johns Hopkins model, and graduation from a CME-accredited school became a prerequisite for state licensing. Many of the smaller, less well-endowed schools were forced to close.

Friendly licensing laws, under which the regulated group is made responsible for its own public regulation, proved to be effective tools of economic warfare. Doctors were not the only ones to seek this protection; barbers and horseshoers, also confronted with runaway competition, went the same route during this period. Less powerful occupations were subject to hostile laws which they could not control. But technology made horseshoers obsolete; and barbers, unable to latch onto the public’s growing awe of science, were less successful in establishing a monopoly through licensing and later turned to unionism to accomplish the same end.

By achieving friendly legislation, ostensibly enacted to control quality, doctors managed to transform their economic desire for monopoly into economic rights. And in codifying these rights into law, they convinced legislators and consumers that the legislation itself was necessary for public protection. Medicine became a profession, and doctors acquired the legal authority to control the trade without outside interference.

Professions Proliferate

This comfortable situation for doctors remained unthreatened until after World War II. Then, the growth of medical technology and the move away from solo practice to complex health institutions expanded the need for categories of allied health workers far beyond the original foursome of physicians, dentists, nurses and pharmacists. Today the workforce includes such groups as radiology technicians, inhalation therapists, medical technologists, laboratory technicians, and occupational therapy assistants. Federal programs have created another, lower category: “new professionals,” noncredentialed workers generally drawn from poor minority communities to do social work, e.g., community mental health workers. In contrast to doctors, all of these groups are employees of institutions, not independent practitioners. Yet each new category has attempted to follow the doctor’s pattern of establishing itself as a profession. Nurses were the earliest imitators (see BULLETIN, April, 1972); now as many as 22 different licensed health occupations exist.

"Medicine’s record for self-regulation has differed little from that of the military investigating the military-industrial complex... The name of the game is whitewash."

—Alex Gerber
The Gerber Report

Inhalation therapy is a typical example. As heart and chest medicine developed and lung complications arose, hospitals trained orderlies to operate the increasingly sophisticated breathing equipment. The American Association of Inhalation Therapists (AAIT) was formed in 1947, and finally sponsored the first national certification exam for inhalation therapists in September, 1970. In early 1970 there were 56 educational programs in inhalation therapy; by October, 1970 the number had grown to 82. In 1971 hiring practices changed as the supply of certified workers increased; hospitals gave preference to certified workers because they carried a guarantee of minimum training and competence, eliminating expensive on-the-job training. Characteristically, certified workers’ wages increased significantly. Membership in AAIT increased over 100 percent, from 6,000 to 12,500 in the last
two-and-a-half years as membership became a prerequisite for certification, and certification became necessary to get a job. Until now two years of experience, successful completion of the test, and membership in the AAIT have been sufficient for certification. At the end of 1973, however, an associate degree from an educational program accredited by the CME in conjunction with the AAIT will be required before taking the exam. State licensing, which will embody the same requirements as those for certification, will probably be required in New York within the year. The regulatory circle is complete.

Even when a worker group achieves licensing, the AMA still maintains control through the accreditation process. Thus the CME, in conjunction with the particular association, accredits 18 categories of allied health training. Moreover, attempts to establish control and security through professionalization backfire by dividing workers into smaller, more easily controllable groups which are forced to bicker among themselves.

The State Board: Enforcing the Barriers

The typical licensing law serves several functions: it establishes entrance criteria for the particular occupation; approves educational programs; ostensibly sets up some system of continuing control over individual practitioners, and defines the scope of practice of each occupation. State boards, which administer the licensing requirements for each occupation, are always composed of practitioners appointed by the state government from lists submitted by the particular professional association. (There are some exceptions. For example, dentists dominate the boards for dental hygienists, and registered nurses run those for practical nurses.) Associations continue to maintain a close working relationship with the boards, which are invariably understaffed and underfunded. Consequently disciplinary and investigatory responsibility are often turned over to the state associations. Office space, employees, and facilities are sometimes shared.

Not surprisingly, the actions of the boards serve the interests of the professional associations. Entrance criteria for the occupations, which mirror the requirements for certification, include membership in the professional association, graduation from an accredited educational program, experience, and successful completion of an exam. Approval of educational programs is turned over to a private accrediting body, usually the CME, and rubber stamped by the state board.

Continuing controls, on the other hand, either do not exist or are ignored. Powers to discipline practitioners through suspension or revocation of licenses are rarely used. Moreover, the boards have created no guarantees against professional obsolescence. Licenses are essentially granted for a lifetime, despite the technicality of relicensing provisions. Yet with no accountability through discipline or relicensing procedures, licensed workers may become institutionalized quacks. Recently, pressure has increased to require continuing education, but professional associations resist substantive changes, claiming that professionals are too busy providing services to undertake further education. Current programs of continuing education are so inadequate as to be meaningless: the Kentucky Board of Dentistry, for example, credits such activities as attendance at local and state dental meetings toward their requirement. Such requirements serve to encourage involvement in the professional association, but do not force practitioners to keep pace with new health science developments.

Finally, scope of practice laws, which are designed to define what tasks a licensed worker can legally perform, are often ignored within institutions without any repercussions. While doctors have unlimited scope of practice, other health occupations have to slice off a narrower piece of the pie—to establish a realm of exclusive expertise—in order to increase their bargaining power with their employers. Registered nurses, for example, cannot legally diagnose and treat; in some states practical nurses cannot administer medications. But behind this legalistic facade, substitutions are constantly made and workers perform tasks for which they are not licensed. "In fact, strict compliance with the law would close many hospitals."

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NEW HEALTH JOB TITLES AND OCCUPATIONS

**Inhalation Therapy:**
- cardiopulmonary technician
- circulation technologist
- respiratory technologist
- respiratory therapist

**Radiology:**
- radiation physicist
- radiobiologist
- radiologic technologist assistant
- radiologist administrator
- radiologist assistant
- radiology aide
- X-ray equipment repair technician
asserted E. Martin Egleston, Hospitals, Journal of the American Hospital Association. Commenting on a well-known practice, one nurse who works in a large voluntary hospital in NYC said, "The difference between RN's and LPN's is that LPN's do at night what RN's do during the day."

While the scope of practice laws appear to have been broken for some workers, LPN's, for example, have no illusions about an increased sense of freedom or power to make administrative decisions. Nor are they financially compensated for the extra duties they perform. When you get right down to it, it's not surprising that institutions don't worry about scope of practice laws, since it is cheaper for them to pay an LPN to do the same work as an RN.

Effects of Licensure on Workers

Clearly licensure laws are not geared to establish quality health services so much as to guarantee a legal monopoly over skills. Thus, licensing increases the economic security of workers in health institutions. Obviously, "the majority of new professionals have to worry about job security and mobility," as Bill Lynch, head of the New Professionals Section of the American Public Health Association, points out. Licensure accomplishes this in two ways.

First, it increases a worker's income. Institutions will accept credentials to avoid the cost of evaluating each applicant for the proper job slot, and to have some assurance of competence without on-the-job training. In exchange, they are forced to pay higher wages, partly because educational levels are most often raised by licensure: "It gives great bargaining power," asserts Lillian Roberts, vice president of the American Federation of State, County and Municipal Employees' District Council 37 (DC 37), which represents hospital workers in New York's municipal hospitals.

Second, credentials, especially licenses, increase the ability of workers to move from job to job and institution to institution, without concern about transferability of skills. On-the-job training, which now varies from 3 to 41 weeks for non-credentialed nurses aides and orderlies, creates problems for workers who wish to change jobs without losing the benefits of their training. Local 1199 of the Drug and Hospital Workers Union is attempting to establish uniform job descriptions in order to assure its workers mobility within the New York City voluntary hospitals. Meanwhile, the legislative department of DC 37 is developing specific laws, including licensing for new categories like obstetrician's aide. Licensing laws cannot, however, create unlimited geographic mobility because licenses are issued state by state, not nationally. Workers must therefore meet requirements in the particular state where they wish to practice.

The advantages for workers are diminished by inflexible requirements for expensive education which have little demonstrable relationship to competence on the job. An inhalation therapist recently complained that the new requirement for accredited education in an academic institution will, in fact, lower the quality of work because such training is less effective than on-the-job training. And by raising entrance barriers, those on the bottom rungs of the economic ladder are effectively excluded from attaining professional status.

Furthermore, licensing nurtures the fragmentation and hierarchical rigidity of the health work force. Educational credit can rarely be obtained for on-the-job training: LPN's must start from scratch, if they want to become RN's. There is little effort toward the creation of core curricula and career ladders; dead end occupations abound.

Control over skills and specific expertise can guarantee worker security, but does

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Growth in Allied Health Manpower

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"I found instead of a clear division of labor in the laboratories, a clear division of laborers into professionals and nonprofessionals."

—Carol A. Brown
The Development of Occupations in Health Technology, 1971
not transform workers into professionals with freedom from outside interference from institutions and other more privileged workers. Rather, it enslaves them to this very expertise, locking them into a structure which discriminates by race, class, and sex. The workers are divided and conquered, while clinging desperately to the small crumbs of security they have managed to wrest from the hierarchy. Meanwhile, white, rich men maintain their monopoly over medicine.

Hospital Interests: Institutional Licensure

The proliferation of occupational groups within institutions has created a chaotic and expensive system of overlapping credentialed groups. Health institutions, and governmental bodies which are increasingly involved in funding health care, are blaming credentialling, and particularly licensing for the health system's high costs and labor shortages. Consequently, both the government and the American Hospital Association (AHA) have concocted the same magic potion: institutional licensure.

First proposed by Nathan Hershey of the University of Pittsburgh Health Law Center, institutional licensure would place responsibility on institutions for appropriate use of personnel and eliminate individual licensing. There's one catch—doctors and dentists, as independent practitioners, would retain their licenses. The state licensing agencies would help create job descriptions, establish qualifications.

Glossary

ACCREDITATION—The process by which the AMA and/or the appropriate professional associations set their standards and then evaluate and recognize an institution or program of study as meeting these standards.

ALLIED HEALTH MANPOWER—A broad term covering all those professional, technical, and supportive workers in the fields of patient care, public health, health research and environmental health who engage in activities that support, complement or supplement the work of physicians, dentists or nurses.

CERTIFICATION OR REGISTRATION—The process by which an agency or association grants recognition to an individual who has met certain predetermined qualifications. Such qualifications may include: (a) graduation from an accredited school or program; (b) acceptable performance on a qualifying exam or series of exams; and/or (c) completion of a given amount of work experience. Although certification is usually done by a private group or professional association, some states have registration by a governmental agency of certain health professions, e.g. physician assistants.

CREDENTIALLING—The recognition of professional or technical competence. The credentialling process may include registration, certification, licensure, professional association membership, or awarding a degree in that field.

EQUIVALENCY EXAMS—Exams used to equate non-formal learning with learning achieved in academic courses or training programs. The exams may be used to grant academic credit for off-campus learning. They may also be used by employers or certifying bodies to qualify people who have learned their skills in other than formal programs. PROFICIENCY EXAMS—Exams measuring an individual's competency to perform at a certain job level—a competence made up of knowledge and skills, and related to the requirements of the specified job.

LICENSEURE—The process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have met some criteria, usually by either passing a standard test and/or by attending an accredited program. FRIENDLY Laws are passed by state legislatures as a response to pressure from the profession to be licensed. The law has the effect of putting control of regulation into the hands of an organized group which controls the state board. Under HOSTILE laws, the regulated group has no say in the licensing regulations which tend to be harmful to its interest.

SCOPE OF PRACTICE—Legal definition of areas of responsibility for a given health profession. In the health field, physicians are given the broadest definitions; other professions are parcelled out smaller areas of responsibility.
and review personnel plans submitted by the institutions. The AHA, in its American plan scheme for national health insurance, proposed that state licensure of personnel as it currently exists be dropped and that health institutions undertake the responsibility of determining the qualifications of all its personnel.

There is no reason to believe that institutional licensure would help workers or patients. Rather, it would simply take control away from the state governments and the professional associations and give it to the institutions. One administrator of a large Eastern voluntary hospital, when asked what changes he would advocate, shrugged and replied that tasks would be pushed down the line: "Maybe LPN's would administer medications." In other words, institutional licensure will enable hospital administrators to save money by transferring jobs from highly-paid personnel to workers with lower salaries. Cost cutting then, not innovative changes in service, is what is meant by "rationalizing" the health labor force.

Best of all, from the hospital administrator's point of view, the hospital would have an iron-clad grip on its workforce. Work discipline would be easier to enforce because workers would know that their economic security was totally dependent upon courting the favor of the hospital administrators. No longer could workers fall back on the security and sense of job mobility which membership in a professional association promises and to some degree delivers.

The AHA clearly regards institutional licensing as a long-term goal which cannot be immediately realized. These proposals do indicate, though, that institutions are preparing to consolidate their control. Predictably, the professional associations are not so keen about the idea. Most vocal are the nurses who have struggled so long to establish an independent identity from doctors. At its last convention the American Nurses Association (ANA) resolved to "protest any effort that could result in replacing the licensure of individual practitioners presently working in institutional settings with a single licensure to the institution." Meanwhile, new and allied health professionals are torn by the fear that the rules of the game will be changed for them, but not for those who already have the protection of licenses.

Their fear is justified. Following a 1971 Health, Education and Welfare (HEW) report, called "Licensure and Related Health Personnel Credentialing," HEW funded an Illinois Hospital Association project to test the feasibility of institutional licensing in six Chicago hospitals. Because currently licensed professions would not agree to cooperate if their licenses were not protected, only unlicensed jobs are being analyzed to determine what tasks should be performed by whom and with what training.

Interim Proposals: The Professional Associations Fight Back

For the time being, an uneasy truce exists while both the AHA and professional associations muster strength to win the upcoming fight over institutional licensure. In the interim, professional associations which have already achieved licensing are exploring various routes to protect their members while eliminating some of the problems which licensure causes. In conjunction with the AHA and HEW, the AMA and ANA have issued position papers calling for a two-year moratorium on licensing of new health categories with defined scopes of practice pending further study of alternatives. The state legisla-
Caught in a Bind

While at the administrative level the dispute goes on, workers feel the reverberations below. They are caught between the AHA and government bureaucrats who want to "rationalize" the health industry by establishing control over the entire institutionally-based labor force, and doctors who want to control the work force by making sure that other health workers are at least nominally under their direct supervision. Union leaders, like DC 37's Lillian Roberts, and spokesmen for unlicensed workers, like Bill Lynch, are suggesting that workers fight for and keep credentials that will improve their bargaining power and economic security— in other words, to try harder to do what workers have been doing all along.

But the continuation of the status quo is no solution. There is a desperate need to lessen the fragmentation of workers and the loss of career mobility which the laws encourage. Credentials which increase economic security unfortunately also divide workers. Changes which might deal with these problems, such as elimination of formal, inflexible educational requirements and provisions that the employing institutions pay for continuing education, will not happen because they are not in the interests of the powers in the health care industry—the doctors and the institutions. The danger is that before pressure comes from workers for unification, changes will be made under the guise of improving efficiency which will increase institutional control, and further alienate workers from their jobs and from each other.

—Emily Spieler

Dear Health PAC,

... I was impressed with Susan Reverby's article in May, concerning the high rate of turnover of nurses in nursing. However, I thought the letter in your September issue from Naomi Appel and Sally Kilby-Kelber (RN's) more accurately describes the concerns of nurses with whom I am acquainted.

Even the most conscientious of physicians often fail to appreciate and utilize the full assets of their nurses and other paramedical staff. Fortunately, as a woman [and a medical student], a good percentage of my friends are practicing nurses and therapists. The majority of medical students, since they are males and less likely to have investigated the paramedics as potential careers, are less familiar with the training received by paramedical personnel. Although my interests and goals are largely the same, it is apparent I will rarely see students of paramedical sciences in the course of my medical training. Medical students are taught that other staff make mistakes and that they must keep a sharp eye to prevent them; MD’s are not taught the converse, that paramedics often see the patient 10-15 times as much each day and they have a lot to tell the attending physician.

I think changes need to be made in the education of future physicians to introduce them to their associates in health care early. I suggest that the introduction take place in the classroom, perhaps by sharing some courses or seminars of common interest, in the basic science years. I do not want one-shot token introduction. I also advocate a different sort of acquaintance than that (usually) provided by medical social fraternities, "student mixers," etc.

Sincerely,

Janice Coverdale
University of Louisville
School of Medicine
The American health system has given birth to yet another occupation: the physician assistant (PA). So welcome was this new arrival that at a time when there were only ten students in training, the Surgeon General was calling the physician assistant "the hottest thing in health care delivery." A television series has already established the physician assistant as a new American hero. Meanwhile, off camera, there are still less than 385 practicing PAs.

Despite all the hoopla, controversy has surrounded the PA from its conception. Was the birth of a new occupation necessary? Why not upgrade nurses or produce more doctors? Debate rages over issues as diverse as what sex should she or he be, and how should the PA relate to other groups in the health hierarchy? There are even more fundamental questions: will the PA meet any of the pressing needs for personnel to provide primary health care and will the PA alter, in any way, the structure and control pyramid in the health system?

The Christening

The American Medical Association defines the PA broadly as "...a skilled person qualified by academic and practical training to provide patient service under the supervision and direction of a licensed physician who is responsible for the performance of that assistant." The concept of an assistant to physicians is obviously not new. Most other members of the health care team "assist" the physician in some manner. The difference is that the PA was developed to be totally dependent upon the doctor for the definition of his scope of practice.

Relieving the physician of his simpler duties, the PA will take medical histories, do physical examinations, instruct patients on specific regimens, write some prescriptions and perform more technical but routine medical tasks like suturing, removing casts, starting IV's, and inserting catheters. The PA will perform even more technical procedures as the assistant to a specialist like a cardiologist or surgeon. Thus, like physicians, PAs can be either specialists or generalists; they can work in private practices or in hospital outpatient departments, in-hospital services, emergency rooms or research labs.

Why Not a Nurse, Why Not a Doctor?

The first PA program was started in 1965 by Dr. Eugene A. Stead, then Chairman of the Department of Medicine at Duke University. The PA was developed to meet two needs: 1) provide specially trained staff to serve the medical center in the face of a nursing shortage, and 2) bring help to the overworked general practitioners of rural North Carolina, where the physician-patient ratio is one-third the national average.

At that time, the Vietnam War was annually producing 6,000 independent medic-type ex-military corpsmen whose training and experience were being lost to the civilian medical world. Most of these men did not continue in the health field because of educational, licensure, and economic barriers, as well as sexual stereotypes (70 percent of health workers and 98 percent of nurses are women) in the health professions. These men were envisioned for the new PA role.

PA advocates at Duke suggested that these men would "stabilize" the predominately female, high turnover labor situation in the health system. In fact, Dr. Stead asserts that since men are more "aggressive" than women, men would make the best "pioneers" for the new profession as it carved out its new role. Of course a PA would also need "a wife at home to care for him so that he can devote full time to the health field," Stead wrote. Moreover, Dr. E. Harvey Estes of Duke argued that nurses cannot work the long hours required because of their responsibility to
“house and home.” Furthermore he said at that time nurses were not “interested in expanding their roles.” These Duke men did not even consider advanced training and upgrading of nurses or day care centers as a means of “stabilizing” the turnover.

The failure of the originators of the PA to see women or nurses in this role is a result of their sexism, their traditional view of women and nurses as “handmaidens” and “housewives,” and their desire to create a new assistant “in their own image” rather than coping with more independent professionals like nurses. The nursing leadership contributed to the male nature of the PA role by refusing to create an alternate to credentialling for the experienced medics, as well as their own drive for supervisory and teaching positions at the expense of developing nurse-clinicians (see BULLETIN, April, 1972). While some “aggressive” women have entered the PA field, many from nursing, aide or technician positions, men still outnumber women more than two to one.

But, as is so often the case, sexism cuts several ways: many doctors feel that the PA should, in fact, be a nurse. A woman is less threatening to a doctor’s image of control than another male. And, of course, a woman assistant can be paid less than a man. For both these power and economic reasons, the AMA, in 1970, issued a unilateral statement suggesting that at least 100,000 nurses could be upgraded into the PA role.

The angered American Nurses Association (ANA), which was just beginning to develop a more clinically-oriented nurse practitioner, responded that the AMA was trying to “rob nursing” to fill in the “doctor shortage.” A Joint-Practice Commission is currently attempting to work out a cease-fire.

Meanwhile, the ANA allegation, regardless of the self-protective and hair-splitting motives, raises a good question: Why not more doctors? Once again the answer has to do with economics and control.

To limit competition, the AMA has historically practiced professional “birth control.” Because of the increasing societal attacks on this policy, the AMA shifted its line from no more doctors to more assistants (at first more allied health workers and currently the PA) which would increase the doctors’ productivity, not to mention his income. The use of assistants doing routine, specialized tasks, serves several functions: it creates a divided workforce on the lower levels, keeps the doctors in control of decision making, maintains the structure of the health system. All in all it is cheaper and less threatening to both the AMA and the American Hospital Association than the creation of many more doctors. No wonder that after some initial trepidation both groups embraced the PA concept.

The Promise

The PA concept was sold to the medical establishment, the mass media and the public as meeting the following needs:

- It would provide new personnel to increase the quantity and improve access to medical care, without the expense of training new doctors.
- It would bring back the personal, community-minded, family doctor type of medicine.
- It would provide a higher entry point into the health system for people who would normally remain in lower level jobs, or, like corpsmen, don’t use their medical skills in civilian settings at all.

The idea caught on: since the inception of the physician assistant program at Duke, with three ex-corpsmen as students, programs have proliferated all over the country. In 1970, there were 67 PA programs. By 1972 the number had climbed to 112, with others in the works as the federal funding fountain was turned on.

Because the term physician assistant can cover almost anybody, diversity has been the name of the game (see box page 12). Programs for PA’s are run by hospitals, medical schools and the federal prison system. Some offer baccalaureate degrees; others give only certificates or...
associate degrees. Some of the programs are tailor-made for ex-corpsmen; others accept people with some health experience, or none at all. Training programs vary. The apprentice-type "Medex" system takes corpsmen for three months of intensive instruction and clinical training at a medical school, followed by a 12-month preceptorship with the primary care physicians for whom the PA will continue to work. The Duke program consists

Thus the AMA objected strenuously to the term "physician associate" since an associate might be construed to be another physician. The National Academy of Sciences tried to settle the debate with a definition having three tiers of physician assistants: Type A, B, and C. This definition parallels both the nursing hierarchy (professional, technical and practical nurse) and the recommendations of the American Academy of Pediatrics for associates, assistants and aides. In spite of

### PA and Practitioner Training Programs

<table>
<thead>
<tr>
<th>Title of PA</th>
<th>Institution</th>
<th>Length of Program</th>
<th>Credential Awarded</th>
<th>Minimum Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Associate</td>
<td>Brooklyn-Cumberland Hospital and Long Island University</td>
<td>2 years</td>
<td>A.A.</td>
<td>High school diploma</td>
</tr>
<tr>
<td>Physician Assistant in Family Practice</td>
<td>University of Oregon Medical School</td>
<td>1 year, 3 months</td>
<td>Certificate</td>
<td>RN</td>
</tr>
<tr>
<td>Medex</td>
<td>University of Washington Medical School</td>
<td>1 year, 3 months</td>
<td>Certificate</td>
<td>Prefer former independent duty corpsman</td>
</tr>
<tr>
<td>Pathology Assistant</td>
<td>University of Alabama at Birmingham</td>
<td>2 years</td>
<td>B.S.</td>
<td>Junior college or hospital corpsmen experience</td>
</tr>
<tr>
<td>Family Nurse Practitioner (Primex)</td>
<td>Cornell University New York Hospital School of Nursing</td>
<td>18 weeks, 7½ months in practice</td>
<td>Certificate</td>
<td>RN currently employed and sponsored by ambulatory services agency</td>
</tr>
</tbody>
</table>


*Selected Examples

of one year of clinical and one year of classroom instruction, with both private physicians and hospitals.

**Good Morning, Osler Jones?**

Naming the new occupation has become even more difficult than determining its sex. Suggestions range from physician assistant or physician associate and Medex (French for "médecin extension" and used for some of the specifically ex-corpsmen programs) to the even more exotic names out of medical history like Osler, Flexner, Cruzer, Korman or the Greek "syniatrist" ("syn" meaning "along with" and "iatric" for "relating to medicine or physician"). The different names reflect the attempt to sell the rather confused role for the PA as a unique, new and important occupation in the health hierarchy. More critically, the name must make clear that there is a pyramid, and that the doctor on top is in control.
AMA objections, many of the more academic, generalist programs are moving toward the use of the term "physician associate." But whatever the name, the essential concern is to establish the PA as the dependent assistant.

An Old-Fashioned Marriage

Health professions usually carve out a piece of turf, codify their "independent" skills and right to control their area, and conduct border skirmishes with those who challenge their position (see accompanying article on licensure). While some of the professions define themselves as independent (nursing being the primary example), in reality they are dependent on the doctor-hospital administrator hierarchy. Control over decision-making and policy direction, not control over routine technical skills, is the actual difference between dependence and independence.

The PA advocates, in contrast, are not making any pretense of independence. In both the law and practice, the PA is to be made dependent. PA legislation is being written primarily as delegation amendments to the Medical Practice Acts, allowing the doctor the right to entrust work to his assistant. What a PA does is thus legally and practically determined by the physician he works for.

Physician control extends to the state level as well. Medical Boards are being given the responsibility to oversee PA programs and certify and register their graduates. However, Nathan Hershey, of the Health Law Center at the University of Pittsburgh, points out, "Placing responsibility for implementation in a board other than a medical board may be necessary, unless one believes that foxes protect and foster the interest of chickens."

Reimbursement procedures also reinforce the dependency role. Under current Medicare rulings, the government will reimburse physicians for PA services rendered under the "direct personal supervision" of the physician. But Medicare will not reimburse the doctor, if his assistant performs services "in place of" the doctor. Nor will they pay for any services provided by the PA under only "general or remote supervision" of the physician. Similar positions have been taken by some of the private insurance carriers. The Health Insurance Council (which represents 317 independent, third party carriers) is working closely with the AMA to set up compensation guidelines. According to Thomas Crain of the Council, it is clear that "we'll compensate as long as the doctor is in control. He's the boss."

Paradoxically, this dependency may give the PA's more leeway over what they do in terms of a range of skilled technical work. But this privilege is not unlike that granted women in an old-fashioned marriage in exchange for their independence. For after all is said and done, the PA will be hamstrung in terms of control over decisions, patient management and innovative changes. If the PA and the doctor disagree, final authority rests with the physician. There is no alimony. The best a dissatisfied PA can do will be to find a marginally better arrangement with another doctor.

For a few PA's, independence may be guaranteed. Some PA's in rural and inner city areas are being groomed as the future general practitioners. For example, two PA's, one in Wyoming and another in Alaska, are now working over 100 miles away from their doctor supervisors. In rural areas, where literally no other medical care is available, PA's may be useful and accepted. But in poor and working class urban communities, use of the PA's is seen as the institutionalization of second

"One needs to recruit manpower with good intelligence and motivation who might have been doctors if the turn of the wheel had given their families a social and financial structure to support the long general and specific education needed to produce a doctor."

—Eugene Stead, M.D.
New England Journal of Medicine,
October, 1967

grams and certify and register their graduates. However, Nathan Hershey, of the Health Law Center at the University of Pittsburgh, points out, "Placing responsibility for implementation in a board other than a medical board may be necessary, unless one believes that foxes protect and foster the interest of chickens."

Reimbursement procedures also reinforce the dependency role. Under current
class care. Thus many inner city communities are wary of the new PA.

Assessing The Promises

Despite the rhetoric, it is becoming apparent, even this early on, that PA's cannot live up to the promises for quality, quantity, access, or lower costs in the delivery of health care.

■ Quantity—Some of the early public relations pieces on PA's promised that a doctor's ability to see more patients would increase 70 percent with a new assistant. A May, 1972 survey of 29 PA's from the Duke Program, however, found that on the whole PA's increased the leisure and reading time for physicians, but did not increase their ability to give additional services. In part the reason is that doctors do not know how to utilize their extra help. As one doctor commented, "After being trained all these years to make decisions myself, how do I begin to trust an assistant and know what to delegate?"

Use of PA's is now beginning to result in a more modest productivity increase for some physicians of between 15 and 30 percent.

■ Quality and Direction—While PA's were hailed as the future general practitioners, specialization has already begun. PA's are now being trained as assistants in such diverse medical specialties as anesthesiology, pathology, surgery, obstetrics and orthopedics. Even graduates from primary care programs like Duke are becoming specialists; for example, Duke-trained surgery assistants are now working at Montefiore Hospital in the Bronx.

The AMA supports this trend since it presents no confusion as to who is the doctor and who is the assistant. Among the first guidelines promulgated by the AMA were those for orthopedic assistants. Hospital administrators and surgery chiefs have written to New York area PA programs requesting more surgery assistants, but not more generalists, for whom they have little use anyway. Since the apprentice must follow the sorcerer, and the latter rarely treads in the areas of preventive and general care, PA's will tend to go with the prevailing norms and salary lures of the specialists.

■ Location—PA's are not going back to the rural scene. Instead the drift appears to be toward non-rural group settings or institutions where the rewards are greater. Recent Medicare rulings accentuate the trend toward institutions. Medicare now allows hospitals, as opposed to private physicians, to bill for all the physician assistants' services as part of the "reasonable cost" of doing business.

An HEW survey of the graduates of 24 PA programs, taken at the end of 1971, demonstrated this trend. Out of 152 graduates, only 40 were working in private practices. Nearly one-fifth (44) were not working as PA's or were teaching or doing graduate work. And the largest number, 68, were based in hospitals and medical centers.

Naturally, some of the larger hospitals are delighted. PA's are already envisioned as the future housestaff because they are cheaper than doctors, do the scut work that is usually reserved for interns, will stay in one place longer than an intern or resident, and can be more easily controlled by the hospital administration and doctors.

■ Costs—At the private practice level, PA's will not lower medical costs to the consumer. Doctors can use PA's to increase their practice, then charge their regular fees and pocket the increase. In contrast to the Medicare administrators (who are sensitive to political outrages about increasing Medicare costs) the more protected Blue Cross-Blue Shield reimbursers are taking a "let's not look behind the billing" attitude, according to HEW officials. If the doctor signs the claim forms, no one is asking who really performed the services. The doctors are being reimbursed as if they, rather than their as-

CORRECTION: The acting chairman of the Department of Community Health at Albert Einstein College of Medicine is William Glazier, not William Glasser, as the October, 1972, BULLETIN reported.

"Just as the marksman must test and adjust his own rifle, the physician must understand and further train his own assistant for maximal effective use."

—E. Harvey Estes and D. Robert Howard
Duke University PA Program
Ms. Nightingale, R.N.
Meets Mr. Osler, P.A.

Organized nursing and medicine have hit in a head-on collision over the PA role. The collision was caused by the abandonment of the staff nurse by nursing leadership, current changes in roles for some nurses and a push by organized medicine to solidify even further its control over the health labor force.

The nursing profession, especially since the middle sixties, has moved at an increasingly rapid pace in its attempt to create both a hierarchy and an "independent" role for nurses. As the doctor stranglehold and the burgeoning allied health professions were advancing on the clinical front, nursing leadership opted to expand the role of its elite members into supervisory and teaching positions.

Meanwhile, dull and routine housekeeping tasks led to unrest and unhappiness among staff nurses, reflected in the continuing 60 percent a year turnover rates and the perennial nursing shortage. A series of nursing reports began to argue for "the re-establishment of practice as the first and proper end of nursing as a profession."

As a result, over 40 "extended" primary care role (nurse practitioner or nurse clinician) programs have developed that prepare the nurse to perform many of the same tasks as are being developed for the PA. The difference between nursing and medicine, at times vague, is becoming even vaguer. As one joint nursing-medical committee put it: "The same act is clearly the practice of medicine when performed by a physician and the practice of nursing when performed by a nurse." While the AMA, clinging to its old definitions, asserts that nurse practitioners are not PA's, the only real difference between the two workers appears to be sex.

As always, behind the sexual politics is the issue of control. The danger that the dependent PA might close the options of the clinically independent nurse is very real. In 1971 New York State's Governor Rockefeller acting on behalf of the state medical and hospital societies rejected the nursing association's bid to expand its scope of practice law. Instead, he signed a law authorizing dependent PA's. In 1972, the nurses were able to get their independent role legislated at the price of agreeing, at least in the legal language, that the nurse when performing medical regimens, would be dependent on the decisions of the doctor.

Eleanor Lambertson, Dean of Cornell's Nursing School and one of the first directors of a family nurse practitioner program, raised the problem succinctly: "Not who does what but who prescribes and who delegates to whom are at issue." Divisions between PA's and nurses are in store. Staff nurses are already edgy about taking orders from a PA and this feeling is not abated when the president of the ANA declares: "Nurses should not take orders from such assistants because a 'profession' does not take orders from an 'assistant.'" Practitioners are already being given the traditional female roles in pediatrics and obstetrics while male PA's are being used in medicine and surgery.

It may be that the nurse practitioner or PA choice will be settled on an institution by institution basis, dependent on the political clout and concerns of the medical boards, the nursing hierarchy and the hospital administrations. The federal officials are trying not to play favorites and granted $6.5 million for nurse practitioner programs, $6.3 million for PA's. While nursing has the numbers on its side, the burden of the traditional image and the rigid jurisdictional outlook of the nursing profession may override economic and power concerns. It is still too early to tell. But it is not too early to note that this conflict neatly ties up the energies of the middle level health workers in border skirmishes, while the doctors continue to reign supreme.
Nursing Shortage?

In July of this year, the California State Department of Finance published a report entitled “Nurses and California.” The central conclusion of the report is that California is training too many nurses and that nursing education programs should be drastically cut. In addition, the report implies that RN’s are overly expensive and suggests that lower paid LVN’s (the equivalent of LPN’s) and aides could replace many RN’s. Therefore, the report predicts that the major problem with nursing in the future will be unemployment rather than shortages.

The report is important since it looks at nursing education from the vantage point of the people who decide on the budget for many of the nursing schools in California. And trends in California tend to spread to other states.

The trend will mean that private health institutions (hospitals and HMO’s), which provide most nursing jobs, will hire as few nurses as possible in order to increase profits. It also means that the need for services in ghetto and rural towns will not be met.

In addition, the report is racist in its suggestion that community colleges might reduce both RN and LVN programs by 50 percent while, on the other hand, the University of California will not be cut back. Since community colleges have provided the largest opportunity for third-world people to enter the health field, the 50 percent cut is a direct strike against more health care jobs for minorities.

Nurses in the San Francisco-Bay Area Medical Committee for Human Rights (MCHR) have analyzed the report and are beginning to publicize its potentially damaging consequences. The MCHR nurses point out that the report is only concerned with costs and has no interest in improved health care. Thus, while many well-trained nurses may be walking the unemployment lines, millions of people will continue to lack access to adequate numbers of health personnel.

made it possible for small numbers of lower level health workers, ex-corpsemen, aides, LPN’s, and technicians to build upon their skills and upgrade their training—a rarity in the dead-ended, lock-stepped health hierarchy. PA programs may provide a way for even smaller numbers of qualified people to get the basic level education necessary for medical schools. Even these gains, however, may be cut by the exclusionary process already at work. For like the other health professions, the PA’s are beginning to follow the doctor model in the development of their “profession.”

Thus an Association of Physician Assistants was formed in 1968 before there were even 20 graduates of the Duke program. By 1970, it had changed its name to the American Academy of Physician Associates to include only Type A, Physician Associate students and graduates. At the same time, at least five other professional associations are competing for PA members, including one group which is backed by a Cincinnati insurance company. An association of the physician associate programs has also been formed. If the definition of PA continues to be as generic and vague as it is now, it can be expected that they will proceed to raise their requirements and erect barriers around their roles. Even now, many PA programs require two or three years of college before acceptance; some have made their PA programs into four-year, bachelor of science in medicine curriculums. This professionalization process may place PA programs out of the reach of most working class and minority students.

Even upon acceptance to a training program, the students may be locked forever into the PA category. The director of the Duke program wrote in 1970 that ideal PA candidates should not be frustrated medical students, otherwise “they’re not going to get enough job satisfaction or ego satisfaction in doing the type of work that a physician will delegate.” Some of the programs in fact discourage students who had originally wanted to go to medical school or, because they are middle and upper middle class men, look like potential medical students.

The PA’s are by no means the new “barefoot” doctors who will revolutionize the delivery of health care. As Dr. Stead so bluntly put it, “They were set up to support the present system.” PA’s are apprentices, created by the sorcerers to do their bidding. And ultimately, unless the sorcerers’ power is challenged by concerted action of all his apprentices, just creating a new, higher skilled occupation will not create much in the way of change.

—Susan Reverby