STATE OF MAINE

LEGISLATIVE RESEARCH COMMITTEE

SUMMARY REPORT

TO THE

ONE HUNDRED AND SIXTH LEGISLATURE

VOLUME ONE

JANUARY, 1973

STATE OF MAINE

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C O N T E N T S

PROPOSED BILLS TO BE SUBMITTED TO THE 106th LEGISLATURE

STATE OF MAINE
LEGISLATIVE RESEARCH COMMITTEE
STATE HOUSE
AUGUSTA, MAINE 04330

January 3, 1973

To the Members of the 106th Legislature:

The Legislative Research Committee hereby has the pleasure of submitting to you its report on activities for the past two years. This summary, designated as Volume I, deals with both assigned and unassigned studies and contains the findings and recommendations pursuant thereto.

The Committee was unfortunate in the loss of its original vice-chairman, the late Representative John E. Gill of South Portland. In his death on July 23, 1972, the State of Maine lost an able public servant. We of the Committee gratefully acknowledge our indebtedness to his ability and his contribution to the work of the Committee.

The Committee also wishes to acknowledge with appreciation the countless public and private individuals, organizations and agencies without whose assistance and cooperation the Committee would not have reached its conclusions.

The members of the Committee appreciate having been chosen to participate in this work and sincerely hope the results of many hours of work and devoted study transmitted here will prove beneficial to the members of the Legislature and ultimately to the citizens of the State of Maine.

Respectfully submitted,

JOSEPH SEWALL, Chairman
Legislative Research Committee

STATE OF MAINE

LEGISLATIVE RESEARCH COMMITTEE

REPORT ON

OCCUPATIONAL LICENSING

to the

ONE HUNDRED AND SIXTH LEGISLATURE

JANUARY, 1973

Legislative Research Committee

Publication 106-16

OCCUPATIONAL LICENSING

WHEREAS, the provision and availability of health care is obviously dependent on health manpower and manpower licensure affects the problems of supply, quality, geographic distribution, and use of personnel; and

WHEREAS, the shortage of health manpower, coupled with increased requirements for health care services, has resulted in a galaxy of new occupational titles; and

WHEREAS, it is estimated that nearly 200 such health occupations now exist and that there will be 20 to 25 supportive personnel for each physician in 1975; and

WHEREAS, it is recognized that needs exist to foster the growth and contributions of the various allied health personnel, to ensure high quality patient care and safety through careful employee preparation and performance and to allow employers to flexibly utilize existing manpower; and

WHEREAS, it appears that the licensing of additional health care occupations may fractionalize further the provision of health services, impede job advancement for employees and hinder management in utilizing new knowledge and technological advances; and

WHEREAS, the furtherance of health care services depends on a more unified approach for preparing, developing and using manpower in a safe and flexible manner; and

WHEREAS, no objective study of licensure and regulatory laws having an effect on health manpower utilization in Maine has ever been conducted by the Legislative Research Committee or by any other objective group representing the welfare of the people; and

WHEREAS, it is the responsibility of the Maine Legislature through the passage of legislation to protect the welfare of its citizens and to protect and promote the effective and safe utilization of health care personnel; now, therefore, be it

ORDERED, the Senate concurring, that the Legislative Research Committee is directed to conduct a detailed review of all state laws and regulations that relate to utilization of health manpower; and be it further

ORDERED, that the Legislative Research Committee shall report its findings and conclusions, together with any proposed legislation bearing upon the subject of this Order, to the next regular session of the Legislature.

HP 1586	House of Representatives	In Senate Chamber
Payson	Read and Passed	Read and Passed
Falmouth	February 24, 1972	March 7, 1972
	Sent up for concurrence	In concurrence

SUBCOMMITTEE ON OCCUPATIONAL LICENSING

CHAIRMAN - Ethel B. Baker

VICE CHAIRMAN - Albert E. Cote

Armand J. Fortier

David J. Kennedy

John L. Martin

The Subcommittee on Occupational Licensing of the Maine Legislative Research Committee was ordered, by Joint Resolution passed by the 105th Legislature of the State of Maine in the Special Session (Jan.24-March 10, 1972), "to conduct a detailed review of all state laws and regulations that relate to utilization of health manpower..." The following is the report of the findings of the Subcommittee to the Maine Legislative Research Committee pursuant to that joint resolution.*

I. Health Manpower Licensure

Each state in the nation regulates most persons providing skilled, professional health services by means of state licensing boards. Fourteen health-related professions are licensed through such mechanisms in the State of Maine--administrators of a nursing home; chiropracters; dental hygienists; dentists; nurses (both practical and professional); optometrists; osteopathic physicians (D.O.'s); pharmacists; physical therapists; physicians (M.D.'s); podiatrists; psychologists; social workers; and veterinarians. The number of health professions regulated by licensing boards in other states ranges from a high of 23 in California to a low of 12 in Alaska, Iowa, Missouri, and Vermont.[1] In addition, professionals employed in certain health institutions are often regulated indirectly by the state or federal government through rules which those institutions must

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* Staff assistance to the Subcommittee was provided by Gary J. Clarke of the Center for State Legislative Research and Service, Eagleton Institute of Politics, Rutgers University.

comply with in order to legally operate, or qualify for particular programs. For example, the personnel of hospitals, nursing homes, clinical laboratories, and ambulance services in Maine are indirectly regulated in this manner.

In order to meet specific time limitations, the Subcommittee on Occupational Licensing has restricted the scope of its study to nine licensing boards governing ten different professions. A single licensing board, the Board of Dental Examiners, regulates both dentists and dental hygienists. In addition, the membership of the Boards of Podiatry and Physical Therapy are composed of two members of those professions, as well as two members of the Board of Registration in Medicine. The State Board of Nursing regulates both professional (R.N.) and practical (L.P.N.) nurses, although in at least one state (California) these separate categories of nurses are regulated by two licensing boards, while in at least two other states practical nurses are included in Nursing Board membership. The nine licensing boards and the ten licensed professions selected by the Subcommittee for study probably represent well over 80 percent of the total number of persons engaged in the delivery of skilled professional health services to the people of the State of Maine.

Precedent for regulation of health manpower personnel by licensing boards in the United States began with attempts to regulate the medical profession. In 1762 a statute was passed establishing the New Jersey Medical Society as the agency in that colony to administer what has become known as the "medical practice act". That law required persons wishing to practice medicine pass certain examinations, and permitted the medical society to exact penalties for

persons practicing without a license.[2] Similar laws were enacted in other states, including Maine in 1821 (P. & S.L. 1821, c56), in response to the shocking lack of training of many who practiced medicine, and the harm to the public which occured as a result. Writing in 1757, the historian William Smith reflected on the problems of health care practice in those times.

> Few physicians among us are eminent for their skills. Quacks abound like locusts in Egypt.... This is less to be wondered at as the profession is under no kind of Regulation. Any man at his pleasure sets up for Physician, Apothecary, and Chirurgen.[3]

The rationale for establishing the first licensing boards was to protect the public from widespread quackery about which Smith and others wrote. State medical societies, in order to ensure a minimal standard of competence for all practitioners and thus protect the public while upgrading the status of the profession, sought mandatory licensure laws for all persons practicing medicine. Due at least in part to the nature and competence of state government at that time, these licensing laws were formulated in such a manner that the professional societies were ensured control of the governmental agency which would administer them--the independent regulatory board.

Although the need for public protection was often not as plainly evident, other health professions also lobbied state legislatures for the passage of regulatory laws based on a model quite similar to the medical practice act. In time, each of the major health professions succeeded in establishing an independent regulatory board to regulate their profession, which was composed

solely of members of their own profession. Almost invariably, these persons could be appointed only from lists submitted to the Governor by the relevant professional society in the state.

Regulation of health professionals by licensing boards was generally accepted by the public and professionals alike for a great number of years as an adequate mechanism for assuring public protection from incompetents and quacks. More recently however, some of the assumed positive effects of the various licensure boards in protecting the public have been called into question, and possible ill-effects on the delivery of health services resulting from the licensure system have been suggested.[4] It has been noted that innovations in the use of health manpower--either through the creation of new categories of health personnel who are not licensed, or through the use of currently licensed persons in areas of practice which normally are reserved to other professionals--tend to be inhibited by the legal structures of the licensure boards and practice acts. It has also been noted that licensure boards determine the competence of an individual only at the time of initial licensure, and thus in the long run do not ensure continuing competence and public protection. It has also been noted that many of the licensure boards are more interested in economic regulation and protection of the individual profession than in public protection. Finally, it has been noted that some health care institutions, such as hospitals, can assure as much, if not more public protection than the licensure boards, and with considerably more flexibility in the utilization of manpower.

The Subcommittee on Occupational Licensing is aware of these recent findings

and criticisms of health manpower licensure boards. It has taken them into consideration in analyzing the particular problems of health manpower licensure and regulation in Maine.

II. The Status of Health Manpower in Maine

In order to study state laws and regulations pertaining to the utilization of health manpower, the Subcommittee on Occupational Licensing of the Legislative Research Committee found it necessary to investigate the supply and distribution of health manpower in Maine.

The current picture in this regard is not a bright one. In almost every important category of health manpower, the Subcommittee found that Maine lags behind national and regional averages in total numbers of health professionals. The distribution of professional personnel is also a great problem, as it is in many other states. Those twin problems of undersupply and maldistribution are certainly a part of the "health care crisis," and restrict the delivery of health care services on an equal basis to all citizens in the State of Maine.

Data compiled by the State Office of Comprehensive Health Planning in 1971 reveal the following comparisons of the overall statewide supply of eight separate categories of health manpower when compared to the national average. Figures are shown in the table below.[5]

Health Professionals Per 100,000 Population

		Maine	United States
Physicians (M.D.'s)	(1968)	99.0	135.0
Osteopathic Physicians (D.O.'s)	(1968)	17.0	6.0
Dentists	(1968)	36.0	47.0
Optometrists	(1967)	12.8	10.4
Pharmacists	(1967)	45.1	62.7
Nurses	(1966)	414.0	313.0
Occupational Therapists	(1966)	3.1	3.8
Radiologic Technologists and Technicians	(1967)	32.0	24.9

Although the number of osteopathic physicians in Maine was almost three times the national average, Maine ranked 25th in the country in the total number of physicians (M.D.'s and D.O.'s) per 100,000 population. Maine also ranked last in the New England region in the total number of physicians.[6] The supply of other primary providers of care--dentists, optometrists, and pharmacists--was also significantly lower than the national average. The supply of nurses, on the other hand, was significantly higher than the national average--although a recent study indicates this situation is rapidly changing in the other direction.[7]

Statewide statistics give only a gross indication of the relative undersupply of important categories of health professionals in Maine. County statistics indicate not only an overall undersupply of health professionals, but a maldistribution within the State as well. For example, in 1970 the number of persons per physician (M.D.'s and D.O.'s) ranged from a low of 581 in Cumberland County to a high of 1,634 persons in Waldo County.[8] In other words, there were almost 3 times as many physicians available to persons in Cumberland County, the physician-richest county, as there were in Waldo

County, the physician-poorest county in the state.

The distribution of dentists follows a similar pattern. Cumberland County had more than four times as many dentists per person as Waldo County, and almost three times as many dentists as Aroostook County.[9] The same distributional problems were evident with regard to nurses. For instance, Kennebec County had almost four times as many active registered nurses per 1,000 population as Lincoln County, and more than twice the number of nurses per 1,000 population as six other counties in the state.[10] Figures on the distribution of physicians, dentists, and registered nurses are shown in the table below.

Distribution of Selected Health Professionals in Maine
(By County)

County	1970 Population Per Physician	1970 Population Per Dentist	1966 Population Per Active R.N.
Androscoggin	805	2,378	266
Aroostook	1,157	4,970	366
Cumberland	581	1,815	173
Franklin	951	3,126	383
Hancock	778	2,573	279
Kennebec	697	2,447	166
Knox	666	2,332	233
Lincoln	1,045	2,834	626
Oxford	1,262	2,523	317
Penobscot	954	3,155	234
Piscataquis	1,165	2,772	308
Sagadahoc	1,047	2,880	227
Somerset	1,517	4,408	420
Waldo	1,634	7,625	447
Washington	1,532	4,158	381
York	1,327	3,257	333

Also important, considering the undersupply of health professionals in the state, is the age distribution of health professionals. The available evidence suggests that younger health professionals settle in the more metropolitan areas of the country. As a result, older physicians and other health workers in rural areas are not being replaced. This raises the prospect of a sharp decline in health services in many rural areas as older health workers retire or die.

This national trend portends serious consequences in Maine, where those counties in need of additional physicians also tend to be those with a higher median age for physicians. For instance, four of the five counties in the state with little or no need for additional physicians also have a median physician age of less than 50 years. Every other county in the state recorded a median physician age of more than 50 years, with the notable exception of Aroostook County, as well as a need for additional physicians exceeding 20 percent of the present supply (including Aroostook). This includes Waldo County, which has the greatest need for additional physicians and the highest median physician age in the state. The figures on median physician age and the need for additional physicians are shown in the table below.

Median Physician Age and Need for New Physician Settlement

County	Percent Increase Needed in Physician Settlement	Median Age of Present Physicians
Androscoggin	5.4%	49.4 years
Aroostook	42.5%	44.0 years
Cumberland	----	46.0 years
Franklin	21.7%	57.0 years
Hancock	----	44.0 years
Kennebec	----	49.2 years
Knox	----	57.0 years
Lincoln	36.8%	50.7 years
Oxford	58.9%	54.0 years
Penobscot	28.7%	50.0 years
Piscataquis	42.9%	54.0 years
Sagadahoc	36.4%	57.0 years
Somerset	78.3%	53.1 years
Waldo	85.7%	62.0 years
Washington	78.9%	52.0 years
York	74.1%	54.0 years

The Subcommittee's examination of the available data leads it to believe that increasing the number of health professionals--especially physicians and dentists--is of paramount importance in solving some of the health manpower problems of Maine. Even more important the committee believes, is ensuring that there is an equitable distribution of health care personnel within different regions and counties in the state.

III. Physician's Assistants

Although Maine has been attracting health professionals in greater numbers in the last few years, the long run prospects of attracting a significantly larger number of health professionals to Maine are not good. Offering generous

scholarships and loans to medical students in return for their practicing in rural areas upon graduation is a device that has met with only mixed success.[12] The Federal government has begun experimenting with sending young physicians to rural areas in Maine and throughout the country; yet the prospects that such physicians will remain in these areas after their two-year commitment is completed is far from certain. Maine has no medical school and few programs of higher education in any of the health fields, which traditionally have attracted health professionals in other states. Numerous studies have shown that physicians (and probably other health personnel) tend to be attracted to metropolitan areas with significantly expanding populations and income.[13] Yet Maine is a slow growing, primarily rural, and relatively poor state. And as the data reviewed in Chapter II indicated, there is already a relative oversupply of most categories of health personnel in the major metropolitan areas of Maine.

The Subcommittee obviously hopes that ways can be found to increase the number and the distribution of several categories of health personnel in Maine. But a realistic appraisal of the chances for an immediate short-run improvement in the situation is not optimistic. However, expansion of available health services to the people of Maine may be achieved in more ways than simply by increasing the number of traditional providers of service. Changing the way in which such existing providers are organized and provide services, such as through the use of prepaid group practice, is an effective and proven manner in some states for utilizing the services of health care

providers more efficiently.

For the purposes of this study, the Subcommittee on Occupational Licensing has examined the possible role of "physician's assistants"--a generic term often used to describe several different types of personnel--in expanding the availability of health services to the people of Maine.

Due to the newness of the concept--the first experiment with physician's assistants began at Duke University in 1965--there has been much confusion on the part of the public and many health professionals about the physician's assistant. The Council on Health Manpower of the American Medical Association has defined a physician's assistant as:

> a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant.[14]

Generally, the training of individuals as physician's assistants is intended to give them the knowledge and ability to perform many of the more routine tasks which traditionally have been performed by physicians. Many nurses, independent duty medical corpsmen who have been discharged from the armed services, and students enrolled in specific programs of higher education have been trained to work as physician's assistants.

The concept of utilizing physician's assistants has attracted a great deal of attention because such an individual can effectively increase to a significant degree the services which a physician can offer. A Duke University study of the practice of one physician using a physician's assistant indicated that

75 percent more patients could be treated at the same level of care by the physician-physician assistant team than the physician had previously treated in solo-practice.[15] A study at Bowman Gray School of Medicine indicated that the assumption of the duties of history-taking, of well-child evaluation and care, and of giving minor medical advice by a pediatric assistant under the direction and supervision of a pediatrician could free approximately half the time of a pediatrician who was formerly a solo practitioner.[16] Perhaps the most extensive study to date determined that the number of patients seen by physicians in nine private practices increased an average of 40 percent since they began using physician's assistants training in the MEDEX program at the University of Washington.[17]

Many persons involved in the training of physician's assistants also believe that such personnel may actually improve the quality of care offered in many private practices by permitting the physician additional time with his more difficult cases. Important but often routine tasks such as thorough history-taking, laboratory testing, and instruction in preventative health--tasks which are often put off by the harried physician due to limitations of time--can also be performed through use of the physician's assistant. And constant supervision by the employing physician can serve as a safeguard against incorrect diagnosis or treatment by the physician's assistant.

In general, acceptance of the concept of physician's assistants by physicians themselves has been quite good. Surveys of members of medical societies in Wisconsin, Kentucky, and Idaho indicated that a majority of

the respondents in each state favored the concept of a physician's assistant.[18] A Louis Harris survey of a national cross-section of 500 physicians indicated that 65 percent believed it would be a good idea to train paramedical assistants to perform routine duties.[19] And a nationwide sample survey conducted by Medical Economics reported that 50 percent of responding physicians would hire a trained assistant.[20]

Documentation of public acceptance of physician's assistants has been rather sparse. However, studies carried out at the Group Health Cooperative of Puget Sound showed that 72 percent of the patients rated the care provided by physician's assistants as highly satisfactory, while 25 percent rated the care as satisfactory.[21] The 40 percent increase in patients seen in practices utilizing MEDEX personnel also seems an indirect measure of consumer acceptance, as increases in comparative control practices averaged only 1.3 percent.[22] Another indication of public acceptance is the excellent record of long established programs providing services similar to those envisioned being offered by physician's assistants, such as public health nursing.

In light of the available national evidence with regard to the beneficial effect of the use of physician's assistants on the quantity and quality of health services available to the public, as well as evidence on physician and public acceptance of physician's assistants, the Subcommittee on Occupational Licensing strongly endorses such programs and the use of their graduates in the State of Maine.

Despite the general acceptance of physician's assistants by many quali-

fied health care experts, however, the Subcommittee on Occupational Licensing has discovered that the present medical licensing laws of the State of Maine may present unnecessary legal obstacles to their employment in Maine. Chapter 48, Section 3270 of Title 32 of the Revised Statutes of the State of Maine specifies the following:

> 3270. Registered Required.
>
> Unless duly registered and licensed by said board, no person shall practice medicine and surgery or any branch thereof, or hold himself out to practice medicine or surgery or any branch thereof within the State by diagnosing, relieving in any degree or curing, or professing or attempting to diagnose, relieve or cure any human disease, ailment, defect or complaint, whether physical or mental, or of physical and mental origin, by attendance or by advice, or by prescribing or furnishing any drug, medicine, appliance, manipulation, methods or any therapeutic agent whatsoever or in any other manner unless otherwise provided by statutes in this state....Whoever, not being duly registered by said board practices medicine or surgery or any branch thereof, or holds himself to practice medicine or surgery or any branch thereof in any of the ways aforesaid.. ..shall be punished by a fine of not less than $100 or more than $500 for each offense, or by imprisonment for 3 months, or by both.

Although the Attorney General of Maine has not been asked to render a formal opinion on this section, it seems clear to the Subcommittee that physician's assistants working in this state may be in violation of the law.[23]

The Subcommittee also notes that nurses working in expanded roles, such as Pediatric Nurse Associates and Family Nurse Associates, who might be

generically termed "physician's assistants" in the broadest sense, may also be working in clear violation of the law. Section 2102, Chapter 31 of Title 32 of the Revised Statutes relating to Nurses and Nursing, in defining the practice of professional nursing, contains the following clear and unambiguous prohibition:

> The foregoing shall not be deemed to include diagnosis of illness or the prescription of therapeutic or corrective measures.

In the opinion of the Subcommittee, such outdated language does not reflect the realities of modern health care. Although both physician's assistants (MEDEX graduates) and various types of nurses working in expanded roles are currently employed by some physicians in Maine, the Subcommittee has received testimony that other physicians have refused to hire these individuals--although they were greatly needed--because of possible legal entanglements. Furthermore, several individuals who are employing these physician's assistants and nurses feel they are assuming a legal risk in doing so. It is the Subcommittee's belief that the Legislature did not intend to legislate circumstances which restrict the delivery of this type of health services to the people of Maine, or permit it only at considerable individual risk.

The Subcommittee on Occupational Licensing therefore believes that it is necessary, from the standpoint of public protection, and from the standpoint of legal protection for the competent physician's assistant and nurse working in an expanded role, to institute some kind of legal mechanism for the regulation of these health professionals. The Subcommittee notes that as of

December 1971, 19 other states with similar restrictive sections in their medical licensing acts had deemed it necessary to pass laws giving legal recognition to, and in most cases regulating, physician's assistants.[24] The Subcommittee believes that such a law is entirely necessary and appropriate at the present time in Maine.

Although it is generally recognized that the development of both physician's assistants and nurses working in expanded roles is a beneficial development which should further promote the ability to deliver universal and economical health care, it also must be recognized that there is currently no standardized notion of the proper training and functions of these individuals. Training programs vary widely in content and prerequisites. The exact types of tasks which can be delegated, the methods by which such delegation can be made, and the accompanying supervision which must be accomplished are not yet clearly defined. As a result, the Subcommittee believes it is inadvisable for the Legislature to strictly define a "scope of practice" for this type of health personnel at the present time.

The multiplicity of such training programs makes it necessary, however, that the Legislature not only formally recognize their existence and their graduates, but also institute a regulatory mechanism to ensure public protection. The Subcommittee on Occupational Licensing believes that the Department of Health and Welfare is the best and most logical agency for the location of such regulatory power. This agency would have the least bias in establishing rules and regulations for regulating physician's assistants and nurses working in expanded roles--a bias which may exist in the

various licensing boards. The Department of Health and Welfare has been given the general charge to protect the public health; it has a large staff and broad expertise; and it should be able to ensure public protection while permitting innovative use of health manpower. It is felt that the Department will be more sensitive to the public, the Governor, and the Legislature than the independent licensing boards. Furthermore, the Subcommittee believes that a review of the individual physician's ability to supervise such assistants and nurses should be undertaken by the medical and osteopathic boards. Such a review would ensure further public safeguards, and include those boards in the proper regulation of the medical and osteopathic professions in this regard.

The Subcommittee on Occupational Licensing therefore recommends passage of legislation similar to that contained in Appendix A of this text. In the opinion of the Subcommittee, such legislation would afford substantial protection to the public, while providing flexible regulation of physician's assistants, and encouraging full utilization of their skills in bringing quality health care to the people of Maine.

IV. The Emerging Health Professions

It has been brought to the Subcommittee's attention that in addition to the legal problems regarding physician's assistants, there are a number of emerging health professions whose legal status in performing health services is unclear. Many of the duties performed by individuals in these professions

are so-called "technical" tasks formerly performed by nurses and doctors, often in experimenting with new knowledge or technology. However, these tasks have now been taught to unlicensed persons without the same formal training as the professional nurse or physician. With the acceptance of this new knowledge or technology as a recognized part of quality medical care, the role of the unlicensed person in carrying out this new knowledge has also become widely accepted by health professionals and health institutions. Inhalation therapy is an excellent example of new technology and accompanying unlicensed personnel illustrating this recent development.

The extremely rapid increase in medical knowledge and technology which characterize the modern age portend that there will be an increasing number of unlicensed health professionals performing tasks which are neither clearly prohibited, nor allowed under present law. Increasing interest and study of task analysis of physicians and other health professionals also portends the discovery of more tasks which can be safely delegated to unlicensed personnel. Yet the statutes of most states, including Maine, make no provision for the legal protection of either the public or the new health professional when the latter is unlicensed, despite the fact that he is providing necessary and medically accepted services. As a result, innovative uses of health manpower, which may either increase the quality of health care or reduce the costs of such care, or provide career opportunities for various health personnel may be unduly restricted.

One obvious solution to this dilemma would be the creation of a new

licensure board and practice act as each new profession defines its area of specialty and becomes medically accepted. However, it has been estimated that there are now over two hundred different health-related occupations in the country. Creation of a licensure board for each category is obviously an absurd and wasteful proposition. Moreover, it has been noted that creation of separate licensure acts tends to inhibit career access and mobility of health professionals, as well as administrative flexibility in the use of such personnel.

The Subcommittee has considered several proposals which would obviate the need for creating new licensure acts, but would provide regulation and legal protection for these new professionals. One of these solutions would be to continually amend the medical or other practice acts to include regulation of new professions under existing boards. While this solution seems particularly suitable to physician's assistants, whose very role is defined as working under the supervision of a licensed physician, it may be less applicable to professions working more independently. Even more important, if legislative approval of every innovation in the use of health manpower were required, then such innovation might be inhibited. And new health professionals would not be protected until such time as sufficient standing was achieved to gain legislative recognition and approval.

Another alternative would be to combine all the health licensure boards into a single board with a single practice act.[25] Such an arrangement would do away with the barriers of statutory distinctions between professions and

thus permit greater career mobility within and between professions. In addition, licensing, and thus legal protection and regulation of new health professionals, would require only administrative rather than legislative action. As a result, such licensing could be attained much more quickly than under the current process. Organization of such an overall board for the regulation of all health professions is not feasible at the present time however.

Still another alternative would be to grant "institutional licensure" power to the State Department of Health and Welfare. The Department could then permit health care institutions to be legally responsible for all their employed personnel (as is the current situation), as well as legally authorized to use employees as it sees fit, without regard to current licensure structures.[26] Although this proposal appears to offer several advantages, such as permitting more flexible use of personnel and offering fewer impediments to career mobility, there appear to be several potential draw-backs. For instance, there is some question whether the State Department of Health and Welfare would be able to effectively administer and monitor such a program. Also, many institutions may be unable or unwilling to assume such responsibility.

To determine the effectiveness of institutional licensure, the U.S. Department of Health, Education, and Welfare has granted a planning contract in Illinois to test the feasibility of the concept, but this idea remains theoretical and untested at the present time. In the case of hospitals, however, decisions reached by the courts in other state jurisdictions seem to

conclude that it is the hospital (as well as the individual), almost regardless of licensure, which is responsible for quality of care. These decisions seem to follow some of the logic of the well-known case of Darling v. Charleston Community Hospital.[27] For instance, the Nevada Supreme Court recently held the following:

> Licensing, per se, furnishes no continuing control with respect to a physician's competence and therefore does not assure the public of quality patient care. The protection of the public must come from some other authority, and that in this case is the Hospital Board of Trustees.[28] (emphasis added)

Although these cases apply only to physicians and await further interpretation before their general applicability to all professions in all situations can be taken for granted, the logic is clearly of general applicability. Further, it does not seem an enormous logical leap to conclude that if licensure does not assure quality care, then hospitals need not be bound by the existence or absence of licensure laws in hiring new professionals or using currently licensed professionals in new and innovative ways. (The Illinois Hospital Association has apparently taken this position with regard to physician's assistants after repeated failure to enact legislation pertaining to regulation of those individuals in that state.) If in fact hospitals throughout the State of Maine are taking this position, then the state must surely take a closer look at the manner in which such institutions regulate their personnel.

Mindful of the two year moratorium on further licensing of health professions recommended by the U.S. Secretary of Health, Education, and Welfare,[29]

the American Medical Association, and the American Hospital Association among others, the Subcommittee on Occupational Licensing is extremely reluctant to recommend any new licensure acts. However, the Subcommittee feels that the current uncertain legal position of new categories of medically accepted and fully qualified health personnel which may occur, and that of employing physicians and hospitals, is a result unintended by previous state legislatures. Such uncertainty is an undue burden for those persons engaged in seeking new ways to better serve the people of Maine. Insofar as this legal uncertainty impedes the delivery of quality care to the people of Maine, it should be removed.

The Subcommittee therefore strongly recommends that a moratorium be declared on further licensure (i.e., passage of a separate statute containing a defined scope of practice and an independent regulatory board), for any of the emerging health professions. In addition, the Subcommittee recommends the passage of legislation substantially similar to that contained in Appendix A of this report. The Subcommittee notes that this legislative draft provides for the regulation of "assistants to physicians." This broad nomenclature was intended to cover not only those physician's assistants and nurses discussed in the previous section, but also members of emerging health professions where there are actual or possible legal conflicts with existing law. The Subcommittee intended that this legislation would remove the legal imperative and political pressure to license new professions often brought to bear upon the Legislature. In addition, it would provide a

mechanism for the dispassionate analysis of the need to give state sanction to these new professions, and provide for registration of those individuals when necessary.

The Subcommittee recognized that such an approach is not an ideal solution to some of the problems of health manpower licensure. But it does represent a flexible short-term solution to some of the possible legal impediments to innovative use of health manpower, while ensuring more public protection than currently exists. This legislation would ensure that important information could be gathered on how new health professionals are being used in Maine. Such information, which is currently unavailable, could provide the basis for a long run solution to many of the problems in health licensure laws studied by the Subcommittee. The broad-based Advisory Committee which would be established by this legislation would ensure representative input from all the currently licensed health professions. The reporting requirement would ensure that the Legislature and the public were fully aware of any actions undertaken by the Department of Health and Welfare.

The Subcommittee believes that this draft furnishes a means by which the health professions, state government, and the public can begin to resolve one of the most crucial problems of health manpower regulation--how to encourage the development of new methods of utilizing health manpower and at the same time furnish adequate public protection.

V. Assuring Continuing Competence of Health Professionals

In the years since the health manpower licensure boards were first established the science and the art of practice in the various health disciplines have changed immensely. When licensure was first initiated, change in health care practice took place rather slowly and examination of credentials upon initial licensure was probably far more important in assuring public protection than periodic reexamination. Today, however, in the field of health care as in so many other areas change is occurring at an ever-increasing speed. The very speed of such change in the health field raises a very real problem that professional skills may become obsolescent unless they are continually updated. Indeed, in a case previously cited the Supreme Court of Nevada went so far as to flatly state that medical licensure provides no assurance of quality care rendered by physicians because such licensure provides no continuing control of competence.

The Subcommittee on Occupational Licensing examined the various licensure statutes and found that only three groups of professionals--osteopathic physicians, optometrists, and chiropractors--were required to show proof of continuing education in order to be eligible for relicensure. In all other cases, once licensure of health professionals in Maine is achieved it is essentially for life, provided only that an annual and usually token fee is paid to the licensure board.

The importance of assuring continuing competence of health professionals in Maine cannot be understated. As a study prepared for the University of

Maine has noted:

> From the perspective of improved health service, continuing education represents the principal resource for the updating, upgrading and diversification of health service personnel.
>
> Maine's dependence on a static supply of health personnel signifies that any early improvement in the quality or quantity of health services must come from an improvement in the capabilities of existing health personnel. Continuing education programs are the principal source for this improvement.[30]

The Subcommittee on Occupational Licensing heard testimony from representatives of most health professions indicating they were personally in favor of requiring continuing education as a condition for relicensure. They pointed out, however, that there may not be enough resources in Maine to implement a program whereby continuing education opportunities are made available to health professionals throughout the State. For instance, a meaningful continuing education program for the large number of nurses in the state might be exceptionally hard to implement, especially if such a program were to be fairly easily accessible. Continuing education programs requiring the professional to leave his practice for a number of days might also work difficult hardships on the community, as well as health professionals, especially in the case of individual practices in rural areas--such as one-man pharmacies.

It was also pointed out that continuing education programs per se may have little meaningful effect on the provision of services. Continuing edu-

cation programs offered by professional societies may be subject to some abuse. More important, many continuing education programs may have little relevance to the health professional's individual practice. Less traditional forms of education, such as an audit of practitioner performance or use of peer-review committees, may also serve to ensure continuing competence.[31] Thus, there appear to be many problems in assuring continuing competence which are ignored by establishment of a simple continuing education requirement.

In reviewing these problems, the Subcommittee felt that the University of Maine might serve as an agent to assist the movement of responsible continuing education programs throughout the state. Academic resources for creating such programs could come from the professional societies, health institutions, and academic health centers both within the state and nationally. Where applicable, the University of Maine and the private colleges could also provide academic resources. But the main role of the University as envisioned by the Subcommittee would be to facilitate movement of programs developed by others. The excellent Educational Television facilities of the University and the regional distribution of its campuses would make it ideal for this task. Indeed the University of Maine itself has envisioned that it might play such a role.[32] Financial support could be derived from educational fees paid by health professionals, or from an increase in the annual cost of relicensure.

After study, the Subcommittee on Occupational Licensing has come to the conclusion that some method of assuring continuing competence of health professionals is imperative. It urges that emphasis be placed on assuring continuing competence, and that continuing education be recognized as one means toward that end. The Subcommittee therefore recommends that the various health professional licensing boards, the various professional societies and associations, the University, the private colleges, and the various health institutions in the state, especially hospitals, formulate a meaningful, workable, and flexible plan whereby all health professionals in the state are afforded the opportunity to keep their knowledge and ability up to high standards. It is further recommended that, as soon as such opportunities are available, all licensed health professionals be required by law to show proof of continuing competence as a requirement for relicensure.

VI. The Structure of the Licensure Boards

Pursuant to its mandate to study the laws relating to health manpower in the state, the Subcommittee on Occupational Licensing examined the various structures of the licensing boards. Surprisingly, the Subcommittee found rather significant differences existed in the composition of these boards.

The number of board members, who are appointed by the Governor in all cases, varies from four to six, as does the number of years of each member's term. Qualifications for board membership, other than being a member of the regulated profession, varies from no specific requirement to ten years experience in the practice of that profession. In only one

practice act is there a restriction on the length of office, and members of only two boards do not have to be approved by the Executive Council.

Members of four boards generally must be appointed from lists submitted by the applicable professional societies to the Governor, while no restriction exists for the remaining five boards. Compensation of board members ranges from $5 a day plus expenses, to $25 a day plus expenses. On one board, members are provided with an annual compensation of $500 rather than a daily sum. Relicensure fees are generally about $5 a year. In one case, relicensure is biennial. In six practice acts members of the health professions who let their license lapse are not required to show proof of competence as a condition for relicensure. In those professions it is theoretically possible for a person to let licensure lapse for 30 years or more and be relicensed simply by payment of a fee. Three practice acts require proof of continuing education as a mandatory condition for relicensure.

In light of the fact that licensing is designed to protect the public interest, the Subcommittee has investigated the possibility of recommending that a public member who is not a health professional be appointed to each of the various boards. In general, representatives of many of the various professions who appeared before the Subcommittee did not object to this idea. There was a pervasive belief, however, that such members could add little to the deliberations of the boards. It was pointed out by these representatives that most actions of the boards were technical and tedious, and only rarely concerned with general policy matters. The Subcommittee believes that despite such

circumstances, it is important that a public member who is not a health professional be included on these boards. His position may be extremely important when basic policy matters are brought up, even if this occurs only infrequently.

Regulatory agencies such as the licensing boards, when controlled exclusively by members of the regulated profession, seem to be suspect in the public mind. J.F. Barron suggests that there seems to be a natural conflict between public and professional interests.

> /Board members/ cannot help but be influenced, if only subconsciously, by the fact that their actions will affect their own and their colleagues' well-being. More importantly, they cannot avoid exposure to the influence of their colleagues and professional organizations. The pressures to which a board is exposed are not those brought by an unorganized and inarticulate public, but those of an articulate professional group which is bound together in well-organized associations.[33]

Lay members may help to bring to the public's attention those matters wherein public and professional interest collide. Furthermore, the presence of public, non-health professional members may help prevent the natural suspicion and loss of public confidence in these regulatory agencies which may result--however unwarranted. The Subcommittee notes that participation of "consumer" or public, non-health professional persons on Comprehensive Health Planning boards throughout the State of Maine has been extremely worthwhile in the development of public policy. In addition, the Subcommittee notes that in other states which have placed public members on licensure

boards, the original uneasiness of board members has been allayed, and the response has sometimes been enthusiastic.[34]

The Subcommittee therefore recommends that a single member who is not a health professional be added to each regulatory board. It is further recommended that this individual not be involved in the administration or ownership of any licensed health care institution or health insurance organization, whether for profit or not, nor be the spouse of any health professional, administrator, or owner.

VII. Summary and Conclusions

In taking testimony and reviewing current problems in the field of health manpower licensure and regulation, the Subcommittee on Occupational Licensing believes that it has covered only a small portion of the relevant material. Not all the health-related licensure boards were included in this study, and problems of regulation of clinical laboratories and bloodbanks and the personnel who work therein were only cursorily considered. The advisability and appropriateness of the use of equivalency and proficiency examinations in licensing health manpower were not discussed, nor were peculiar administrative problems of the various boards. In the Subcommittee's opinion, many of the long range problems of health manpower regulation require more information and far greater agreement among the various health professions than has yet been achieved. Nevertheless, the Subcommittee believes that is has pinpointed the four most pressing concerns with regard to health manpower laws in Maine.

First, legal protection for physician's assistants and nurses working in expanded roles, and their employers, as well as public regulation of these individuals, should take place as quickly as possible. Although the training and utilization of these physician's assistants and nurses has not been standardized and specifically defined, their proven value in improving the delivery of health care is not in dispute. The present legal uncertainties surrounding their full utilization and employment should be abolished, as so many other states have already done. The Subcommittee believes that its proposal to do this is clearly in agreement with the recommendations made by the Secretary of the U.S. Department of Health, Education, and Welfare.[35]

Second, enactment of legislation that would establish new categories of health personnel with statutorily-defined scopes of functions is clearly an undesirable alternative, and the Subcommittee joins with the Secretary of HEW in recommending a moratorium on such legislation.[36] However, some long range flexible solution must be found to provide regulation as well as legal protection to those persons engaged in providing quality health care through the innovative use of health manpower. The present uncertainty with regard to the pertinent legal issues is undesirable, as is the prospect that such issues may be settled de facto by the courts, or else be assumed by the hospitals to be settled, without health professionals or state government having any role to play. The Subcommittee recommends the passage of its legislation in order to achieve a short-run solution to some of the possible legal problems of the emerging health professions and provide the information

and the forum wherein a long range solution can be found.

Third, provided it was sufficiently flexible, a mandatory requirement for proof of continuing competence as a condition for relicensure, appears necessary in light of today's conditions. Such action was recommended in the HEW Report on Licensure, etc.[37] Continuing education and proof of continuing competency are significant avenues to upgrade the quality, and possibly even the quantity of health services available to the people of Maine. Implementation of additional programs in this field should be undertaken by professional societies, health care institutions, and the University.

Fourth, the lack of representation of the public viewpoint on the various licensure boards should be corrected. Such action was also recommended by the Secretary of HEW.[38] Consumer representation has a beneficial place in any regulatory agency, especially in health care where the public's welfare is directly at stake.

Finally, the Subcommittee notes that changes in the financing and delivery mechanisms for health services, and increases in the supply and distribution of certain health professionals may have more to do with increasing the public's health and satisfaction than any changes recommended in the health licensure laws per se. Nevertheless, changes in such laws may have substantial beneficial long term effects on the delivery of health services. The legal anachronisms of another era certainly should not hinder the delivery of modern health services to the people of Maine. More important, health professionals, health institutions,

state government, and the public must begin the arduous task of devising together a long range solution to the continually recurring and myriad problems of health manpower regulation.

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APPENDIX A

An Act Relating to the Sanction and Conduct of Assistants to Physicians.

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. R. S., T. 32, § 2706, additional. Title 32 of the Revised Statutes is amended by adding a new section 2706 to read as follows:

§ 2706. Osteopaths

Nothing contained in this chapter shall be construed to prohibit osteopaths from delegating certain activities relating to osteopathic medical care and treatment to persons not licensed as osteopaths, if such activities are conducted under the supervision and control of a licensed osteopath, provided that these persons have satisfactorily completed a training program approved by the Department of Health and Welfare. Supervision and control shall not be construed as requiring the personal presence of the supervising osteopath at the place where such services are rendered unless such physical presence is necessary to provide patient care of the same quality as provided by the osteopath. Nothing in this chapter shall be construed to prohibit a student enrolled in an approved program for training such assistants from rendering services when and if such services are rendered as part of the conduct of the training program and are under the supervision and control of a licensed osteopath. The osteopath delegating such activities, either to program graduates or to participants in an approved training program, shall be deemed legally liable for such activities of such persons and such persons shall in this relationship be construed as the osteopath's agent.

Any delegation of activities pursuant to this section shall be subject to the following restrictions:

1. Vision. When the delegated activities consist of the measurement of the power or range of human vision; or the determination of the accommodation and refractive states of the human eye or the scope of its functions in general or the fitting or adaptation of lenses or frames for the aid thereof; or the prescribing or directing the use of or using any optical device in connection with ocular exercises, visual training, vision training or orthoptics; or the prescribing of contact lenses for or the fitting or adaption of contact lenses to, the human eye, the person to whom such activities are delegated must possess a valid license to practice optometry in Maine. Nothing in this paragraph shall be construed as prohibiting the independent practice of optometry. The performance of routine screening of visual acuity, visual field testing, ocular movements and physical examination of the eye and associated structures may be delegated by physicians to a person not licensed as an optometrist;

2. Dentistry. When the delegated activities are part of the practice of dentistry as defined in section 1081 and following or dental hygiene as defined in section 1095, then the person to whom such activities are delegated shall possess a valid license to practice dentistry in Maine or be otherwise approved by the Board of Dental Examiners;

3. Podiatry. When the delegated activities are part of the practice of podiatry as defined in section 3551; that person to whom such activities are delegated shall possess a valid license

to practice podiatry in Maine or be otherwise approved by the examiners of podiatrists;

4. Pharmacy. When the delegated activities are part of the practice of pharmacy as defined in section 2801, then the person to whom such activities are delegated shall possess a valid license as a pharmacist or be otherwise approved by the Board of Commissioners of the Profession of Pharmacy.

The Board of Osteopathic Examination and Registration shall include a review of an individual osteopath applicant's ability to delegate such activities and supervise the activities of assistants as part of the determination of an applicant's suitability for being registered as a licensed osteopath. Permission to employ or supervise such an assistant may be withdrawn or withheld from an individual osteopath by the board upon presentation of evidence satisfactory to the board that the individual osteopath is not capable of delegating activities or supervising such assistants in the best interests of the public health. The board shall notify any osteopath from whom such permission has been withdrawn or withheld of such action in writing. Any osteopath from whom permission to delegate and supervise activities has been withdrawn or withheld may appeal such action by requesting in writing a hearing from the board within 10 days after notice of the board's action. Any osteopath who employs, supervises or otherwise delegates activities to an assistant after such permission has been withdrawn or withheld shall be punished by a fine of not less than $100 nor more than $1,000 for each offense. A 2nd violation of this section may be construed as

grounds for revocation of license to practice or other disciplinary action by the board pursuant to section 2705. Records of such activities by the board shall be confidential.

Registry of delegates, approval of assistants' training programs, studies of delegated activities and relationships shall be outlined and defined in section 3295.

Sec. 2. R. S.,T. 32, § 3295, additional. Title 32 of the Revised Statutes is amended by adding a new section 3295 to read as follows:

§ 3295. Physicians

Nothing contained in this chapter shall be construed to prohibit physicians from delegating certain activities relating to medical care and treatment to persons not licensed as physicians, if such activities are conducted under the supervision and control of a physician or surgeon, provided that these persons have satisfactorily completed a training program approved by and registered with the Department of Health and Welfare. Supervision and control shall not be construed as requiring the personal presence of the supervising physician at the place where such services are rendered unless such physical presence is necessary to provide patient care of the same quality as provided by the physician. Nothing in this chapter shall be construed to prohibit a student enrolled in an approved program for training such assistants from rendering services when and if such services are rendered as part of the conduct of the training program and are under the supervision and control of a licensed physician. The physician delegating such activities, either to program graduates

or to participants in an approved training program, shall be deemed legally liable for such activities of such persons and such a person shall in this relationship be construed as the physician's agent.

Any delegation of activities pursuant to this section shall be subject to the following restrictions:

1. Vision. When the delegated activities consist of the measurement of the power or range of human vision; or the determination of the accommodation and refractive states of the human eye or the scope of its functions in general or the fitting or adaptation of lenses or frames for the aid thereof; or the prescribing or directing the use of or using any optical device in connection with ocular exercises, visual training, vision training or orthoptics; or the prescribing of contact lenses for or the fitting or adaption of contact lenses to, the human eye, the person to whom such activities are delegated must possess a valid license to practice optometry in Maine. Nothing in this paragraph shall be construed as prohibiting the independent practice of optometry. The performance of routine screening of visual acuity, visual field testing, ocular movements and physical examination of the eye and associated structures may be delegated by physicians to a person not licensed as an optometrist;

2. Dentistry. When the delegated activities are part of the practice of dentistry as defined in section 1081 and following or dental hygiene as defined in section 1095, then the person to whom such activities are delegated shall possess a valid license to practice dentistry in Maine or be otherwise approved by the Board of Dental Examiners;

3. Podiatry. When the delegated activities are part of the practice of podiatry as defined in section 3551; that person to whom such activities are delegated shall possess a valid license to practice podiatry in Maine or be otherwise approved by the examiners of podiatrists;

4. Pharmacy. When the delegated activities are part of the practice of pharmacy as defined in section 2801, then the person to whom such activities are delegated shall possess a valid license as a pharmacist or be otherwise approved by the Board of Commissioners of the Profession of Pharmacy.

The Board of Registration in Medicine shall include a review of an individual physician applicant's ability to delegate such activities and supervise the activities of assistants as part of the determination of an applicant's suitability for being registered as a licensed physician and surgeon. Permission to employ or supervise such an assistant may be withdrawn or withheld from an individual physician by the board upon presentation of evidence satisfactory to the board that the individual physician is not capable of delegating activities or supervising such assistants in the best interests of the public health. The board shall notify any physician from whom such permission has been withdrawn or withheld of such action in writing. Any physician from whom permission to delegate and supervise activities has been withdrawn or withheld may appeal such action by requesting in writing a hearing from the board within 10 days after notice of the board's action. Any physician who employs, supervises or otherwise delegates activities to an assistant after such permission has been withdrawn or withheld shall be punished by a fine of not

less than $100 nor more than $1,000 for each offense. A 2nd violation of this section may be construed as grounds for revocation of license to practice or other disciplinary action by the board pursuant to section 3284. Records of such activities by the board shall be confidential.

The Department of Health and Welfare shall maintain a registry of persons who are graduates of approved programs and who are otherwise approved by the department to accept delegation of activities from physicians. The department may from time to time specify certain activities that may or may not be delegated to certain assistants to physicians based upon their training, skills or performance. No person not so registered shall be permitted to function as an assistant to a physician in Maine and it shall be unlawful for a physician to delegate activities to a person not so registered. The department will specify the format to be used in applying for such registration and registration is to be renewed annually. Every applicant shall pay the department a fee of not more than $25 for initial registration and not more than $10 for yearly reregistration. The department may require a lesser fee. Failure to register as an assistant to a physician, in accordance with this section, shall be punished by a fine of not less than $25 nor more than $500. However, any person already licensed as a physical therapist, podiatrist, optometrist, pharmacist, registered nurse, licensed practical nurse, dentist or dental hygienist may be registered by the department without payment of a fee and upon presentation to the department of evidence of licensure and whatever other information the department may require.

The Department of Health and Welfare shall maintain a registry of approved training programs for persons to accept such delegation

in Maine. Approval of programs shall be on the basis of curriculum, qualifications of training staff, methods of evaluation of trainee performance and method of trainee selection. No training program shall be approved unless it is associated with an approved college or university, a teaching hospital or similar educational institution sanctioned by a duly constituted governmental body. The department may charge any institution applying for approval for such a program a fee not to exceed $1,000 but sufficient to defray the costs of approving the program. The department may use formal approval by an out-of-state training program by an official agency of another state's government as evidence of adequacy if it determines such action to be in the public interest.

All such fees collected by the Department of Health and Welfare under this section will be credited to the General Fund.

In approving applicants for registration, approving training programs and studying the functions and limitations of assistance to physicians, the department shall be advised by a committee to be called the Advisory Committee on Assistants to Physicians and consisting of one member elected by each of the boards of registration or licensure of physicians and surgeons, physical therapists, podiatrists, osteopaths, optometrists, pharmacists, nurses and dentists and 11 additional Maine citizens to include a hospital administrator and 3 persons not professionally associated with health care. The members of this group of 11 Maine citizens shall be appointed by the Governor from a list prepared by the Commissioner of Health and Welfare. The members of this committee shall serve for 2-year terms coincident with the legislative biennial.

The Department of Health and Welfare shall conduct studies into the nature and scope of the duties and tasks of these assistants to physicians in order to promote effective functioning

and utilization as members of the health care team. The department shall report to the Legislature no later than January 30, 1975, and thereafter in each regular session or as required by the Legislature, as to:

1. Programs. The number and types of programs which have been approved and a description of each;

2. Number. The number of physicians' assistants who are functioning in the State and the nature and character of the supervision exercised over them by their supervising physicians;

3. Information. Information about the physicians supervising such personnel, the specialties and geographic locales in which they practice;

4. Activities. The types of activities being performed by these persons and the effectiveness and economy with which they deliver these services;

5. Institutional relationships. Information about the institutional relationships enjoyed by these persons functioning as physicians' assistants and the type of supervision exercised in the institutional relationship;

6. Supervision. Specific information about the type of supervision exercised when the supervising physician is not physically present or readily available to the site of practice of the assistant;

7. Other information. Any other information pertaining to the evaluation of these activities or as specified by the Legislative Research Committee.

Sec. 3. Appropriation. There is appropriated from the General Fund to the Department of Health and Welfare the sum of $5,000 to carry out the purposes of this Act. The breakdown shall be as follows:

	1973-74	1974-75
HEALTH AND WELFARE, DEPARTMENT OF		
All Other	$2,500	$2,500

Statement of Fact

Traditionally, over the years, physicians, both allopathic and osteopathic, have delegated certain activities to other persons not licensed as physicians in order to facilitate and economize the delivery of health services. Over the past several decades, such delegation has increased in amount and the type of activities which have been delegated have increased in complexity such that the appropriateness of such delegation is now unclear under the present physician, osteopathic, nurse, dentistry and related practice acts. Furthermore, this type of activity has prompted the development of programs to train other types of physician assistants and nurse practitioners who will be available to accept delegation of such activities, and it is generally recognized that this development is a healthy one which should further promote the ability to deliver universal and economical health care. Because the development of these new kinds of programs is still experimental, the programs vary widely in content and prerequisites, and the exact types of tasks which can be delegated and the methods by which such delegation and the

accompanying supervision must be accomplished are not clearly defined. It does not seem appropriate at this time to enact specific restrictive licensing or certifying legislation. However, it does seem appropriate for the Legislature to formally recognize that such delegation does take place, that it considers an appropriate aspect of medical practice when done under close supervision, and that those who wish to carefully and productively experiment in the various ways in which it might be done should be afforded a certain degree of legal protection as long as their activities are in the interest of public health and not detrimental thereto. The Legislature also recognizes the need for the collection for more detailed information about these activities so that more specific legislation may be enacted at some future date when it is in the public interest.

The intent of the Legislature in passing this particular bill is to instruct the Department of Health and Welfare to automatically approve programs which are recognized by various licensure boards. In doing so, other health care professionals such as podiatrists, optometrists, opticians, registered nurses, licensed practical nurses, and other health professionals presently licensed by the State would automatically be determined as appropriate persons to whom physicians may delegate certain tasks under supervision. In addition, it is anticipated that the department would automatically approve already established and proven training programs for other health personnel, such as medical technicians, x-ray technologists, surgical technicians and the like. It is anticipated that the department would more closely examine new or innovate programs with the assistance of the various licensing agencies and approve only

those which were conducted by a recognized educational facility using appropriately trained and licensed instructors and designed to train personnel to meet specific needs. In passing such legislation, the Legislature would thereby recognize the existence of physicians' assistants, sanction this existence, require that close supervision of their activities be conducted and instruct the Department of Health and Welfare to carefully examine the methods by which they have been trained and approve only those methods which in the judgment of the department are in the interest of the public health. Such activities are consistent with the general charge given to the Department of Health and Welfare by the Legislature to protect the public health.

This legislation is intended to be a formal statement by the Legislature of a "moratorium" on the enactment of specific licensing legislation pending the results of the inquiries conducted jointly by the Department of Health and Welfare, the various health professional licensure bodies and other concerned persons through the advisory committee created herein.

APPENDIX B

HEALTH PROFESSIONAL LICENSING AND REGULATION BOARDS

Profession	# on Board	# Yr. Me. Prac.	Length of Term	Limit Terms of Office	How Appt.	Method of Appt.	Comp.	Relicensure Fee	Relicensure Cont. Educa. Requirement
Physician & Surgeon	6	5	6 yr.	None	Govern. w/Ex.Cl.	No Restriction	$500/yr.	$5/ Biennially	No
Physical Therapists	4-2 P.T.'s	No Ref.	4 yr.	None	Governor	List of 3	$5/day + expen.	$ 5	No
Podiatrists	4-2 Pod.'s	2	4 yr.	None	Governor	No Restriction	$25/day + expen.	$ 5	No
Osteopaths	5	3	5 yr.	None	Govern. w/Ex.Cl.	No Restriction	$10/day + expen.	$ 4	Yes
Optometrists	5	5	5 yr.	None	Govern. w/Ex.Cl.	No Restriction	$10/day + expen.	$ 5	Yes
Pharmacists	5	10 yrs. exper. No Me. Ref.	5 yr.	None	Govern. w/Ex.Cl.	List of 6	$20/day + expen.	$ 5	No
Nurses & Nursing	5	3 + various No Me. Ref.	5 yr.	None	Govern. w/Ex.Cl.	List of 6	$15/day + expen.	$ 2	No
Dentists	5	5	5 yr.	No. Appt. After 10 years	Govern. w/Ex.Cl.	List of 6	$15/day + expen.	$ 4	No
Dental Hygienists	5-0 D.H.'s	Not Applicable (NA)	NA	NA	NA	NA	NA	NA	No
Chiropracters	5	3	5 yr.	None	Govern. w/Ex.Cl.	No Restriction	$10/day + expen.	$10	Yes