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ABSTRACT

The principal address was by Ralph C. Kuhli, entitled "Education of Health Manpower for the 1970's." He called for recruitment of workers into general rather than specific health occupations, development of educational programs for allied medical occupations, organization of a national joint accreditation commission, encouragement of students and employers to prefer AMA-accredited programs, proficiency testing, supported by grant, governmental medical facilities as models, and health maintenance systems. Reports were made to the General Session by the chairman, the immediate past chairman, the executive director, and the treasurer. Seven groups met and presented recommendations concerning health manpower data collection, licensing, education, continuing education, recruitment, screening and placement, utilization, and mental health manpower. Discussion group data is tabulated and participants are listed. (MS)

FOURTH ANNUAL

HEALTH MANPOWER CONFERENCE

October 3-4, 1969

Sponsored By

HEALTH MANPOWER COUNCIL OF CALIFORNIA
No. 1 Camino Sobrante
Orinda, California 94563

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C O N F E R E N C E

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CALIFORNIA HEALTH MANPOWER CONFERENCE

San Diego, California October 3-4, 1969

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HEALTH MANPOWER COUNCIL OF CALIFORNIA

1969 HEALTH MANPOWER CONFERENCE

October 3 - 4, 1969

KONA KAI CLUB

San Diego

A G E N D A

Friday, October 3, 1969

4:00 p.m.	Registration
5:30 - 7:00 p.m.	No Host Reception
7:00 p.m.	Dinner
	Featured Speaker - Mr. Ralph Kuhli, Director, Department of Allied Medical Professions and Services, Division of Medical Education, American Medical Association

Saturday, October 4, 1969

8:00 - 8:45 a.m.	Late registration
	Complimentary coffee served
8:45 a.m.	General Session
10:30 - 12:00 p.m.	Discussion Group Sessions
12:15 p.m.	Lunch
1:30 - 3:30 p.m.	Discussion Group Sessions
3:45 - 5:00 p.m.	General Session
5:00 p.m.	Adjournment

* * *

OPENING SESSION - HIGHLIGHTS

The Conference was formally opened by Dr. Cullen, who then introduced Mrs. Sylvia Marshall, Program Planning Committee Chairman for the Conference. Mrs. Marshall, in turn, presented the members of the Planning Committee: Dr. Virginia Barham, Nursing Education Consultant, Board of Nursing Education and Nurse Registration; Miss Jean Clawson, Consultant in Health Education, The California Community Colleges; Miss Ann Lewis, California Department of Employment, Consultant to the Health Manpower Council; Dr. Eugene Miller, California Medical Association; Mr. Michael Peevey, Member, Health Manpower Council; Dr. Ruth Sumner, Assistant Associate Regional Health Director for the Bureau of Health Manpower, Region IX, United States Department of Health, Education, and Welfare; Mr. Russell Williams, Member, Health Manpower Council.

The Conference program plan was outlined by Mrs. Marshall, who stated that the discussion groups had been designed solely to develop practical steps toward solving specified problems in health manpower. Since the two days constituted a "working conference," participants were charged with identifying obstacles to improved manpower, and with proposing workable and obtainable solutions to these specified problems. Mrs. Marshall said, "Emphasis is on 'here and now' solutions," rather than on academic directions. Discussion Group Leaders were identified. (See page 35 for roster of leaders and topics).

Dr. Cullen introduced Mr. Ralph Kuhli, Director, Division of Allied Health Professions, American Medical Association, for the evening major address.

* * * *

"EDUCATION OF HEALTH MANPOWER FOR THE 1970'S

Ralph C. Kuhli, M.P.H., Director
Department of Allied Medical Professions and Services
Division of Medical Education, American Medical Association

California is my home state, so it is a special pleasure for me to meet with the Health Manpower Council of California, and to discuss with you the "Education of Health Manpower for the 1970's.' At this Health Manpower Conference I am particularly interested in discussing your participation in national programs. California has one-tenth of the population of the United States, so doing what I can to involve California more actively in the national decision-making process has been the primary objective of my conferences this week in San Francisco, Los Angeles, and now this weekend in San Diego.

Health Manpower has been identified as the top priority need by coalitions of national organizations and agencies, and fundamental change is a predominant characteristic of our times. Changes in education for the health occupations are much too rapid and radical to be called evolutionary; I believe we are in the middle of what might be called a revolution in education for health occupations.

I propose to discuss aspects of this revolution in terms of what we should be doing. Of course, it's easier and customary to talk, study, explore, confer, and report. All of us have had the experience of going from one convention to the next to hear scholarly discussions of health manpower shortages and mal-distributions, with recent emphasis on 'non-systems'. Some of us feel satiated with talk which is not related to productive action. For example, think about how much has been said and written about employing more of the 30,000 military medical corpsmen discharged annually, but little has been done about it!

Addressing myself to all of us in the education and the health professions concerned with the education of health manpower, I move that we:

1. Recruit people of all ages to the Health Occupations in general, rather than to specific professions.

2. Develop educational programs for fewer health occupations rather than more -- perhaps aides and attendants at the post-high school level, technicians and assistants at the junior college and lower division level of colleges and universities, and technologists and therapists baccalaureate level.

3. Organize some kind of national joint commission for the accreditation of educational programs for the health professions.

4. Encourage students to take AMA-accredited allied medical educational

programs, and employers to prefer graduates of such programs.

5. Support grants to registries so they can offer proficiency testing for all who want to qualify to work in health occupations.

6. Support budget requests of governmental medical facilities so they become models of effective and economic delivery of health services.

7. Teach the delivery of health services as a customer-oriented health maintenance system which requires management and teamwork.

I propose to assume that someone seconds each of these motions and I will speak on each proposal briefly.

I. RECRUITMENT TO HEALTH OCCUPATIONS

Health careers recruitment programs tend to be directed to specialized, specific occupations: we seek students for educational programs for a specific profession or service. High school students are encouraged to make a choice, and apply for admission to one specialized course of study. There are few transfers -- students become drop-outs or graduates. It reminds me of driving on a super highway, with no stops and no turn-offs for the next 26 miles. We can do better. We health professionals should get out of the way of the educators so that high school and college guidance counselors, and directors of allied health educational programs would know that they may recruit students to the general field of health occupations, and that at any point a student may transfer from one allied health educational program to another with appropriate credit for past education and experience. Those of us who are in national professional health associations do not have the right to tell institutions of higher education that no credit may be given for appropriate courses taken in some related field, and that all transfer students must always "start over."

The same concept of lateral and upward mobility is applicable to students whose formal education is interrupted. Do you know that the average age of a junior college student is 27? Medical schools average a 10% attrition; what happens to medical students who drop out of medical school? Why don't we have the equivalent of a Bachelor of Medicine degree? Why don't we recruit more drop-outs from medical schools to educational programs for the allied medical occupations?

In Summary:

Let us recruit interested high school students to the health occupations, preferably giving them opportunities to observe many kinds of health workers on the job in hospitals, laboratories, clinics, and physicians offices. Let the first quarter or semester of post-high school education be a time for

general orientation and introductory instruction, possibly with courses in anatomy, physiology, medical terminology, and medical ethics. The student could use this exploratory period to select some one of the range of choices for special study, and the instructors could use this time to evaluate the student's interests and potential.

II. FEWER OCCUPATIONAL TITLES

Almost three and a half-million workers are employed in the health occupations:

MEDICAL: There are about 330,000 physicians, more than 170,000 other independent practitioners, and a half-million allied medical workers.

DENTAL: The 101,000 dentists have about 145,000 dental auxiliaries.

NURSING: There are 680,000 Registered Nurses, about 260,000 Licensed Practical Nurses, and perhaps 800,000 aides, orderlies, and attendants.

OTHERS: Finally, there are about 425,000 environmental and public health and other health workers.

More than 2,000,000 of these are allied health workers, splintered into 200 or more separate occupations. Some of the allied health workers are allied to physicians as members of the health care team in the delivery of health services to patients. The AMA Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services has the staff of the AMA Department of Allied Medical Professions and Services at work on a chart of educational levels of allied medical occupational levels:

AIDES. For allied medical occupations which require a high school diploma and some additional formal or on-the-job training, we have listed a dozen kinds of aides plus the surgical and emergency medical technician and the certified laboratory assistant.

TECHNICIANS AND ASSISTANTS. About two years of higher education are offered in hundreds of hospitals, as the lower division of many 4-year colleges and universities, and in many hundreds of junior or community colleges. Our list currently includes fifteen kinds of technicians, six kinds of assistants, and the Cytotechnologist, Orthotist, Prosthetist, and Radiologic Technologist.

TECHNOLOGISTS AND THERAPISTS. A baccalaureate degree or some equivalent is required for seven technologists (five of them in the medical laboratory), seven therapists, and other professionals, including the medical record librarian, biomedical engineer, dietitian and

nutritionist, and the audiologist and speech pathologist.

To date, we have tentatively listed a total of 65 different allied medical occupations, and, of course, there are many more in the dental auxiliaries; the aides, orderlies, and attendants who work with nurses; and the specialists allied to environmental and public health professionals.

I would like to see us give more attention to cumulative levels of education, like rungs in a ladder, so a student could climb as far and as rapidly as time, money, and ability would permit. If a person dropped out of high school, he or she should be able to start work with some entry-level responsibility and with opportunities to learn in on-the-job training. One example is the so-called New Careers program. If the high school graduate is hired and given some months of on-the-job training or up to nine months of higher education, why couldn't he be called an 'aide' without the compulsion to add modifiers which narrow the title to some specialty? This is done in other industries.

Similarly, why can't we use the more general occupational title of 'technician' or 'assistant' for people who have completed about two years of hospital and college education? Of course, I don't mean that they would be competent in all fields, but their special education and competence should be seen as a quality and a qualification rather than a box.

And, finally, the college graduate could be identified by us all as a technologist or therapist, with some appropriate corollary background information concerning the special area of competency.

III. JOINT COMMISSION FOR ACCREDITATION

The National Commission on Accrediting is an independent educational agency supported by about 1,400 colleges and universities who pay annual dues ranging from $25 to $200 depending on their enrollment. 'The Commission is designated by consent of its members to speak and act for them with respect to policies and procedures of accrediting agencies whose operations directly affect the administration or procedures of institutions of higher education.' [1] This is non-governmental self-governance in America, in contrast to foreign countries where educational programs are controlled by the government.

There are two types of accreditation:

A. General Institutional Accreditation of High Schools and Colleges and Universities of higher education by six regional associations, which have a Federation of Regional Accrediting Commissions of Higher Education.

B. Specific Program Accreditation by national professional associations of programs for professional study. This was begun by the AMA in 1906, and now professional accreditation is conducted in nearly thirty fields.

The National Commission on Accrediting was organized by colleges and universities after WW II to decrease the numbers of accrediting agencies and increase the quality by recognizing a strictly limited number of organizations which are judged by ten stringent criteria.

The AMA Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services and its Panel of Consultants now has before it an important proposal for a major national study of accreditation in the Allied Health Professions and Services, funded by several foundations and possibly the federal government and conducted with the formal participation of appropriate organizations representing both education and health. The initial consideration of this proposal will be at an October 17 meeting in Chicago.

December 17 in Washington, the National Commission on Accrediting will hold a National Conference on Accrediting for representatives of the professional associations recognized for the accreditation of specific educational programs. The objectives of this meeting will surely include a review of the NCA 'Code of Good Practice in Accrediting in Higher Education' and of the 'Criteria for Recognized Accrediting Organizations.'

The more than 200,000 members of the AMA, through their Council on Medical Education, spend a lot of time and money working for the accreditation of medical schools and educational programs for thirteen allied medical occupations, but do not feel a 'territorial imperative' on such accreditation.

The AMA Division of Medical Education has drafted a proposal to expand the existing Liaison Committee on Medical Education (of the Council on Medical Education of the AMA and the Executive Council of the Association of American Medical Colleges) to form a Commission on Medical Education which would serve as the central authoritative body for medical education in the United States. This proposal is under active consideration, and discussions continue.

The need for a joint commission for accreditation of schools for many kinds of health professions has been mentioned at meetings of the Federation of Associations of Schools of the Health Professions. The point is that the many national professional organizations in education and health concerned with the accreditation of schools of the health professions should work together -- preferably in concert with the regional accrediting associations -- to make the whole process more effective and useful to colleges and universities and less costly in time and money. Our preference is for an inter-organization Joint Commission working with the National Commission on Accrediting and the U.S. Office of Education.

IV. AMA-ACCREDITATION

Dr. C. H. William Ruhe, Director of the AMA Division of Medical Education, points out that organized medicine recognizes that it has great responsibility to, and that it must be actively aware of and related to,

all the allied health fields for one important reason: that all of the allied health workers find their focus, indeed their reason for existence, in the care of the patient; and where the care of the patient is concerned, the physician ultimately has legal, moral, and ethical responsibility. As the major professional organization for physicians, the American Medical Association feels this responsibility keenly, and believes that it must increasingly be involved with the collaborating organizations in coordination, guidance, and direction for the multiple, increasingly fragmented components of the health care team, through which the care of the patient is provided.

The patient is the reason for our occupational existence. We should ask ourselves the following questions in order:

1. What services are needed by the patient?

2. How can these services be provided most effectively? (Maybe the system or the equipment can be improved; all problems are not solved by additional people!)

3. Can the people in existing health occupations provide these services most efficiently?

4. If not, what new allied medical occupation is needed?

5. What, exactly, are the tasks which this new allied medical occupation will be expected to perform? (Here we begin talking about performance standards).

6. What educational program is needed to develop the necessary proficiency to perform these tasks?

We ask interested national organizations to take the first five steps in cooperation with the AMA Council on Health Manpower. If and when it has been determined that an existing or a new allied medical occupation is a necessary member of the health care team, the Council on Health Manpower formally recognizes the occupation and refers it to the Council on Medical Education.

We are asked two simple questions:

1. What is your concept of a good educational program for an allied medical occupation?

2. Which schools now offer such programs?

It takes a lot of work to provide good answers to these questions, and the work at the national level is done by fifteen collaborating professional associations:

1. American Academy of Orthopedic Surgeons

2. American Association for Inhalation Therapy
3. American Association of Medical Assistants
4. American Association of Medical Record Librarians
5. American College of Chest Physicians
6. American College of Radiology
7. American Medical Association
8. American Occupational Therapy Association
9. American Physical Therapy Association
10. American Society of Anesthesiologists
11. American Society of Clinical Pathologists
12. American Society of Medical Technologists
13. American Society of Radiologic Technologists
14. Society of Nuclear Medical Technologists
15. Society of Nuclear Medicine

In answer to the question, 'What is your idea of a good program?, these organizations provide a brief outline of what they think is essential for an educational program for an allied medical occupation (and the single page or two on which these minimal requirements are outlined is called 'Essentials').

In answer to the question, 'Which schools are offering such programs?,' these organizations provide a list of the hospitals and colleges which are offering educational programs which meet or exceed these minimal requirements.

The need for the AMA and these collaborating organizations to function as the accrediting body is recognized by the National Commission on Accrediting and the U.S. Commissioner of Education. They recognize the six regional associations which grant general institutional accreditation to colleges and universities. Regional accreditation does not include the evaluation of educational programs in colleges and universities. Both the National Commission on Accrediting and the U.S. Office of Education designate the Council on Medical Education of the AMA in collaboration with the other professional associations directly concerned to accredit baccalaureate programs for the medical record librarian, medical technologist, occupational therapist, and physical therapist.

The Commissioner of Education also recognizes the AMA and collaborating organizations to accredit these same educational programs and a growing list of others for allied health professions. For the purposes of determining eligibility for federal assistance and as required by Public Law 82-550 and subsequent legislation, the U.S. Commissioner of Education is required to publish a list of nationally-recognized accrediting agencies and associations which he determines to be reliable authorities as to the quality of training offered by educational institutions.

This is 'An interlocking framework of cooperation -- among the agencies and between agency and government' [6] which we value very highly. The AMA Council on Medical Education, in collaboration with the other national professional health associations, currently accredits educational programs for thirteen allied medical occupations:

1. Certified Laboratory Assistant
2. Cytotechnologist
3. Inhalation Therapy Technician
4. Medical Assistant
5. Medical Record Librarian
6. Medical Record Technician
7. Medical Technologist
8. Nuclear Medicine Technician
9. Nuclear Medicine Technologist
10. Occupational Therapist
11. Physical Therapist
12. Radiation Therapy Technologist
13. Radiologic Technologist

Essentials for the Orthopedic Assistant are being submitted to the AMA House of Delegates and could be adopted at their December meeting in Denver; for the Histologic Technician have been approved by the American Society of Clinical Pathologists and the American Society of Medical Technologists, and are now being submitted for adoption to the AMA, starting with the Advisory Committee on Education for the Allied Health Professions and Services at their meeting October 16th; and for the Medical Laboratory Technician, they have not yet been written.

V. REGISTRIES

Mr. S. M. Miller, A Program Advisor in the National Affairs Division of the Ford Foundation, wrote an article on 'Breaking the Credentials Barrier' in the March issue of Training in Business and Industry[2]. Mr. Miller says 'we have become a credential society, in which one's educational level is more important than what he can do.... We have a new guild system of credentials, licenses, certificates -- largely built on the base of education -- which keep people out of many occupational channels....' He concluded: 'All of us know of individuals who cannot get jobs that they would be able to perform well because they lack the appropriate credentials -- whether it's a high school diploma or a Ph.D.'

How does this relate to the news that here in Southern California malpractice insurance rates doubled, effective October 1st? In our discussion of credentials, we are concerned with licensure, registration and certification. Each person seems to use words like registration or certification (and licensure!) to mean what he says they mean, and does so quite emphatically. I'm told that a license is permission to do something, and that it's granted by a government. I understand that registration/certification is usually a function of non-governmental organizations. Incidentally, the word 'accreditation' is reserved for the approval of educational programs or of institutions, and should not be used as applying to persons.

Liability, Legislation, and Licensure

Of course, the practice of medicine includes activities ranging from the routine and repetitive to those which require advanced training, skill,

and judgment. Obviously, it's wasteful and inefficient to require ten or more years of college, medical school, internship, and residency to qualify a person to perform routine duties which can be learned in a few months or years of specialized technical training. Many routine medical functions are generally delegated to laboratory and x-ray technologists and technicians, to medical assistants in doctors' offices and to many other allied medical workers. During recent decades, we have seen the development of dozens and even hundreds of allied health occupations.

As Dick Bergen of the AMA Law Division points out: 'The difficulty arises from the fact that the health and well-being of a patient is not something that can be divided. Even the most routine procedure may be critically important. It may cause a crisis which requires the training, skill, and judgment of a physician to save the patient.... Accordingly, for the protection of the patient, medical functions can be delegated to paramedical personnel, only if they are performed under the direction and supervision of a physician.... If a physician knows that an assistant is qualified to perform the particular procedure and if it is under his direction which is sufficiently close and detailed to prevent harm to the patient in the event of untoward developments, he may properly delegate complicated and delicate procedures to the assistant.'[3]

There is understandable concern about the possibility of increased liability for damages which may arise from extended use of allied medical personnel. An employer physician is liable for an injury caused by the negligence of his employee, even if the employee is another physician. This liability extends to all subordinate levels of employees as well. The physician accepts this burden of liability for his assistants, and the lack of registration, certification, or licensure does not generally impose a serious legal risk on the physician employer.

As Dick Bergen points out: 'Possession of a license or certificate.... is no guarantee against negligence.'[4] It is the physician's responsibility to see to it that his patients are in safe hands when receiving care from allied medical personnel. A physician can delegate to competent allied medical workers under physician supervision virtually any medical procedure which does not, on a scientifically-determined basis, require the personal knowledge, skill, and judgment of a Physician.

California presents a particular problem because this state has a larger number of official allied health classifications than any other state and has a strict Medical Practice Act.

New kinds of allied medical personnel are assisting physicians in new ways -- Dr. John Niebauer's 'Orthopedic Assistant' program in San Francisco is one example -- and it seems inevitable that such medical innovations must increase risks. Of course, the risk is lessened if the assistant is thoroughly trained and carefully supervised. It is reduced still further if a formal educational program is established and operated effectively, preferably in conjunction with a medical school or a teaching hospital. It is minimized further if appropriate medical specialty and allied medical

professional associations collaborate with the AMA Council on Medical Education to establish 'Essentials' (standards for education), and there is a program for private certification/registration of students who satisfactorily complete the approved training. Compulsory state licensing does not further reduce the risk for the employing physician.

Certification/Registration

There are several health manpower problems which might have a surprising common denominator -- problems concerning:

Discharged military medical corpsmen -- 30,000 a year!

Graduates of proprietary schools and of innovative programs (shorter educational programs, some with teaching machines, simulated lab work, and home study courses).

Foreigners.

People who have had long experience in the health occupations, but who lack the currently recommended or required formal education.

The registry is emerging as an increasingly important solution to a number of major problems. It would be most helpful for foundations and the federal government to make the substantial grants necessary for registries to work with others concerned to develop nationally accepted lists of tasks for allied health occupations, and to develop examinations which would measure any applicant's competency to perform these tasks for allied occupations. Then the registries could determine the proficiency of anyone -- a discharged military medical corpsman; a graduate of a foreign school; a graduate of a school which is not currently accredited by the AMA, including proprietary schools; a person with long experience; etc. The registries could, and I think should, register or certify without further examination all graduates of AMA-accredited educational programs. Such registries would stimulate innovation, help solve manpower problems, minimize over-education and provide registration/certification which would be much more desirable than state licensure. I re-emphasize how important it is for foundations and the government to grant registries the sums needed to develop proficiency examinations.

VI. GOVERNMENTAL MEDICAL SERVICES

In the September 16th Congressional Record, Senator Ribicoff is quoted as speaking of $18.3 billion in total federal health expenditures' and he spoke of a 'spread of federal health programs across 23 separate departments and agencies.'[5] In 1967, the AMA Department of Survey Research reported a total of 27,552 physicians in the employ of the federal government, and 24,917 of these were engaged in total patient care.[7] The Veterans Administration has no less than 100,000 beds in 165 hospitals.

I understand that at least 10,000,000 Americans are getting their total medical care from the federal government.

When I was Assistant Coordinator for Medical and Health Sciences in the Office of the President of the University of California, I was impressed with the qualities of the medical service provided at the Los Alamos Scientific Laboratory, funded by the Atomic Energy Commission. For me, this became an example of how excellent governmental medical services can be, and, I propose, should be.

The budgets of governmental medical staffs and facilities should be so well supported that governmental medical services become models of effective and economic delivery of health services.

Since our government controls its own hospitals and other medical facilities, it can demonstrate now how to hire and utilize retired military medical corpsmen, how to provide lateral and vertical mobility for allied health people by giving them responsibilities and remuneration commensurate with their competencies.

To do this, all of us must support our government in its efforts to make its health services into the well-organized health system called for by government spokesmen.

VII. MANAGEMENT AND TEAMWORK

When I look at the delivery of services by business and industry, I can't help but be impressed by the efficiency and cost-consciousness of businessmen, as well as by the excitement of newer and better ways of doing things.

We drive into a huge new shopping center, and it is easy to find a place to park. We go to a new hotel or motel, and find satisfying services to meet our needs. We drive into a Standard or Texaco filling station (in any corner of the United States), and our credit card answers all questions of who we are and how we propose to pay the bill. New products and new services compete in the marketplace of our free enterprise system.

I like that, and I would like to see the management competencies of big business applied in partnership with the medical profession for the more efficient delivery of more health services. I think we have a management problem, in health, and I would like to see top-level managers of our free-enterprise system solve it.

I would like to see an 'agglutination' of the health facilities and personnel of a community in a campus-like health center surrounded by parking space. Helicopters as well as automobiles would improve the transportation of trauma cases as well as other medical emergencies. I would like to see a front entrance and reception area -- open night and day, 365 days a year -- with the civilian equivalent of the military Triage: the

sorting out of medical and dental cases, to determine priority of need and proper place of treatment. I would like to see an identification card coded to computerized information to take the place of the reiteration of one's personal health history, and the need for hospitalization to qualify for insurance payments. I would like to see a one-story motel-like facility for out-patient and admitting services, and office and clinic space rented to physicians and dentists practicing privately. You can add much more to this picture, and, of course, much of this is already happening at places like Baylor, the Cleveland Clinic, Mayo Clinic, and Kaiser Permanente.

Such campus-like health centers, renting office and clinic space to health departments and voluntary health associations as well as to practicing physicians, would be a splendid location for the clinical parts of allied medical educational programs. Such a center would facilitate achievement of many of our educational objectives: members of the health care team who are going to work together would learn together; medical students could have clerkships and other clinical experiences in doctors' offices and in group practice settings as well as at the episodic and really atypical teaching hospital which is normally used today; students could more readily work part of the time and learn the rest of the time; and education could become the life-long continuum which is really needed in the health professions, partly because physicians could get away to spend time on continuing their formal education without neglect to their patients.

Recently, I have been hearing more references to the four-day work week. I don't believe in it. I would much rather see us retain the five-day work week, but encourage the employee to spend one of the five days continuing his formal education. If we spent one full day each week continuing our formal educations on the campus and in the clinical setting, we could earn enough academic credit to qualify for an advanced degree. Under such a plan, employers could require professional employees to earn an additional graduate degree each decade and non-professional office employees could earn baccalaureate degrees. This is the Kuhli plan: four days in the office and one day on the campus, all as part of the job. I think it's much better than the four-day week.

People, as well as places, need to come together in some organized way to meet patient needs. Instead of bouncing -- like a ball in a pin-ball machine -- from one health professional to another. The patient should be cared for by people who cooperate as members of a health care team.

I look at this subject from the point of view of the patient. When I and my family need medical care, we go to a doctor of medicine. He (or she) determines the diagnosis and treatment, often in cooperation with other members of the health team. In fact, the physician has other members of the health team provide many or most of the diagnostic and therapeutic services -- after all, there are about fourteen other health workers for each physician. Physicians are the first to say that allied medical professionals provide certain services better than the physician does, because of specialized education and experience. What's more, allied

workers provide such services more economically; the health worker with two to four years of higher education is paid less than one with ten to twelve years. All this does not mean diagnosis by a committee: the physician is in charge and is responsible. So my family is cared for by a health team. Sure, the physician is the captain of the team, but in a manner comparable to a football team: one of the members of the team is captain but the ball is handled by many members of the team. I take a dim view of an allied medical profession trying to become independent. I'd rather see an allied medical professional organization define how the allied medical professional cooperates with the physician as they discuss and agree on the diagnosis and treatment of their patient. In union there is strength, and I prefer to be cared for by a health team which is cooperating.

By the way, one-fifth of all Americans move every year, and this mobility is well known to Californians. A family is served by several kinds of doctors and allied health workers; and when the family moves, a whole new set of health workers take over. Medical and dental records for each member of the family might -- or might not -- be transferred to the new location. This mobility is one more reason for the need for management and teamwork in the delivery of health care services.

* * * * * * * * *

The education of health manpower for the 1970's is an exciting, challenging opportunity for us to make our professions and organizations part of the solution rather than part of the problem. I have urged that we do this by:

1. Recruiting people of all ages to the health occupations, leaving the selection for specialization as part of the educational program.

2. Working for fewer occupational titles rather than more, and using educational levels as one general identification for workers.

3. Helping the health and education professions to work together to set national standards, possibly by establishing a joint commission for accreditation of educational programs for the health occupations.

4. Encouraging students to attend AMA-accredited educational programs, and hiring graduates of such schools.

5. Approving grants to registries, so they can develop and use proficiency tests for all interested to determine competency to work.

6. Support governmental medical services so they become models, exemplifying all the qualities of efficiency and economy described so eloquently by governmental spokesmen.

7. Forming a partnership with big business management so the health care team can deliver better health services for everyone.

All of this starts with education, and we can do much about this here, now, and together.

REFERENCES

[1]The Constitution of the National Commission on Accrediting -- approved by the constituent members of the Commission and accepted by its institutional members.

[2]S. M. Miller, 'Breaking the Credentials Barrier,' Training in Business and Industry, Gellert Publishing Corporation; March, 1969.

[3]Richard P. Bergen, 'Use of Irregular Paramedical Personnel;' Journal of the American Medical Association, Vol. 207, No. 5, pp. 1027-8; Feb. 3, 1969.

[4]Richard P. Bergen, 'Irregular Assistants and Legal Risks,' Journal of the American Medical Association, Vol. 207, No. 6, pp. 1231-2; Feb. 10, 1969.

[5]Congressional Record, 91st Congress, First Session; Vol. 115, No.148, pp. S-10594 to S.10609; Sept. 16, 1969.

[6]William A. Kaplin and J. Phillip Hunter, 'The Legal Status of the Educational Accrediting Agency: Problems in Judicial Supervision and Governmental Regulation,' Cornell Law Quarterly; Vol. 52, pp. 104-131; 1966.

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Following Mr. Kuhli's presentation, the session was adjourned.

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Saturday, October 4, 1969

GENERAL SESSION I

CHAIRMAN'S PRESENTATION: Stuart C. Cullen, M.D.

In opening the program, Dr. Cullen noted that the session included the formal annual meeting of the Health Manpower Conference of California. The purposes of the Health Manpower Conference and the Health Manpower Council were briefly described, including these major points:

> The Council by-laws state -- ".... The specific and primary purposes for which the corporation is formed are to assure adequate health manpower for California by determining present and future needs for health manpower in California, determining alternative means of meeting these manpower needs and facilitate the accomplishment of these purposes, and to develop and make available to all interested parties facts and information pertaining to the efficient and sound development of a program for the recruitment, education and training of medical, dental, nursing and allied health personnel to meet the present and future needs of California."
>
> The by-laws further state -- ".... The membership shall be divided into two classes, council and conference.
>
> The council membership shall be composed of the members of the Board of Directors of this corporation. Council members shall be the voting membership, and no other class of members shall be entitled to vote.
>
> The conference membership shall consist of such individuals, partnerships, corporations, associations and others having an interest in the specific and primary purposes of this corporation approved for membership by the Board of Directors.
>
> The dues, if any, shall be established by the Board of Directors. (Note: So far, there are no dues, although this may be necessary in the future).
>
> An annual meeting of the conference members shall be called by the Board of Directors each year and thirty days notice of such annual meeting shall be given. The Board of Directors shall make a report concerning the activities of the corporation at each annual meeting of the conference members."

Members of the Council present at this session were introduced by the Chairman:

Leland Baldwin; California Community Colleges

Alfred Baxter; Member-At-Large

Gordon Harris, D.D.S.; California Dental Association

Frank Melone, M.D.; California Medical Association

Clifton Linville; California Hospital Association

Sylvia Marshall; Member-At-Large

Donald Page; California Department of Employment

Mrs. Berenice Stevens; California Association of Medical Laboratory Technologists

Rheba deTornyay, Ed.D.; California Nurses' Association

Russell Williams; California Hospital Association

REVIEW OF COUNCIL ACTIVITY: Mr. Richard Highsmith

Mr. Highsmith, immediate past chairman of the Council, presented a brief history of the Council, along with a description of its current Council activities.

He stated that in October of 1966 the first conference on health manpower was held in Santa Barbara. This group of outstanding participants determined that an organized approach was needed to coordinate the programs of agencies which were involved in manpower. A second state-wide health manpower conference was held in February 1967, resulting in the decision to organize a Health Manpower Council of 25 members, representing both health interests and public interests. In May, the organizational meeting of the Council was held under the temporary chairmanship of Dr. Lester Breslow, then Director of the California State Department of Public Health.

The first meeting of the newly incorporated Health Manpower Council of California was held in June 1967, and the following objectives were established:

1. Manpower studies and research. Realistic identification of manpower needs, and information on practical ways to meet these needs were essential.

2. Policies and methods. Development of policies and adoption of methods which would correct manpower deficiencies.

3. Coordination of health manpower activities. Much work was going on in various parts of the state but many agencies facing the same problems were unaware of each other's work.

4. Counsel and service. Professional counselling and information would be an important service to agencies and would enhance the performance of all participants.

In August 1967, the first officers of the Council were elected. Subsequent Council meetings in October and December were devoted to reports, but it was apparent that staff was necessary to advance the Council beyond being just a good idea. After exte sive interviewing, Dr. Ken Briney was selected as Executive Director of the Council. Dr. Briney arrived in January 1968, to provide staff service to the Council.

It soon became apparent that many statistical figures were being applied to health manpower which were actually unreliable and inaccurate. The real manpower situation in California could not be determined from existing information. Therefore, the Council undertook a state-wide manpower survey in the summer of 1968, with funds provided by Comprehensive Health Planning. The results provided reliable basic data on the nature and extent of health manpower shortages in the state.

Mr. Page, meanwhile, had made the full-time services of Miss Ann Lewis available to the Council, making it possible to conduct this manpower survey and several other studies. Following the Survey, Miss Lewis designed a pilot project to test a technique of training a person in a hospital department to conduct task analysis of jobs within the department with the goal of restructuring the department for maximum utilization of manpower.

Other activities of the Council included co-sponsorship of a state-wide conference on mental health manpower, in cooperation with the California Nurses' Association and the California Psychiatric Technicians' Association.

A third Conference on Health Manpower was held here in San Diego in November 1968. The scope of health manpower problems was almost overwhelming, but the participants were enthusiastic about beginning to develop solutions.

In the past year we have had discussions with Comprehensive Health Planning, which has come into being since the Council was formed. Mr. Spencer Williams, Chairman of the Comprehensive Health Planning Council, has indicated his intention to utilize the services of the Health Manpower Council, particularly in manpower studies and research.

A Council Task Force on recruitment of students to health careers, chaired by Byron Rumford, developed a series of recommended actions. Many of the recommendations had to be shelved due to a lack of available funds. However, the first recommended action was carried out, resulting in the publication of a directory of California resources for information on careers in specific health occupations. Mr. Donald Page subsequently had 10,000 copies of this pamphlet reprinted, with Council approval, and has made it available through local offices of the State Department of Employment and Youth Opportunity Centers.

These examples show the kinds of work the Council has been doing. The problem has been to equate the demand for service with our limited resources. The organization has been set up, and a structure exists to carry out the established objectives.

Mr. Highsmith expressed special appreciation to the members of the Executive Committee for their diligence in working through problems of getting the organization established and operating.

* * *

Dr. Cullen acknowledged the progress made in founding the Council and in beginning an attack on the tremendous problems of health manpower. The Council is facing a critical point in which it is well organized and has identified specific problems which need solving, but it lacks the resources to do the job it has defined.

Dr. Cullen stated that many organizations have some component devoted to health manpower. There is bound to be duplication, overlapping and gaps with so many separate approaches. The Council offers an important means of bringing these organizations together for a more efficient and effective attack, quite aside from the value of the Council's own programs. This coordination effort may develop into the primary objective of the Council. Support from concerned agencies is required to accomplish this objective.

It is not possible to manage the health manpower problems in this state with the services of only two staff people. More personnel must be obtained by some means, perhaps through projects, grants, or contracts. The Council needs to move ahead, to demonstrate the value of this kind of voluntary organization of persons and agencies concerned with health.

Participants are urged to develop specific courses of action in the discussion groups. Some of the problems have been identified; now we must proceed the problems without further delay.

* * *

EXECUTIVE DIRECTOR'S REPORT

The report of staff activity was presented by Kenneth L. Briney, Ph.D., Executive Director of the Council.

"EXECUTIVE DIRECTOR'S REPORT

Kenneth L. Briney, Ph.D.

This is the second annual report of the Executive Director, and it shows a great deal of progress for the Health Manpower Council toward the goals and objectives which were mentioned by Mr. Highsmith.

The goals and objectives were developed in June 1967, when the Council was formed. They have proved to be valid and continue to provide the framework for our operations. The four major categories are:

1. Studies and research
2. Policies and methods
3. Coordination
4. Counsel and information services

RESEARCH

In adopting goals and objectives, it was agreed that priority in the first years of the Council would be given to studies and research in order to clarify specific manpower problems, and develop practical solutions, pulling together the existing data and information relating to health manpower, specifically as it applied to California. Unfortunately, we found very little information which was valid, reliable, and up-to-date. No information was available to show the current status of health manpower in California, and conflicting reports about "manpower shortages" were widespread.

We soon determined that a study was required to find out what was the actual situation. Did we have a health manpower crisis or not? A survey of major employers of health manpower in California was designed -- and subsequently directed by Ann Lewis. Comprehensive Health Planning provided funds. The preliminary results were reported at the Conference here on November 23, 1968.

The results were surprising. The vacancy rates were less than 5%, for forty counties, and over 10% in two counties. Analysis of the data revealed considerable variation from county to county in vacancies.

The Survey was important in that it provided up-to-date information on personnel needs. These were 'real' needs since they represented vacant positions which would be filled if qualified persons were available.

Our report was printed early this year, and was an immediate best seller -- so much so that we have made a second printing. For the county-level planners and for others who need detailed information, we also have a publication showing the data according to each institution surveyed.

The results of this Survey exceeded our expectations in the amount and accuracy of information obtained. The study is being used in many areas and localities as a first step in determining local health manpower status. However, we are the first to point out the limitations of that Survey. It is only a beginning. We hope, now, to be able to build an on-going system of data collection to give us needed information on a regular basis. One of the discussion groups at this Conference is devoted to the problems of data collection and use.

Another major area of research has related to study of utilization of personnel. Our greatest resource in health manpower is among the health workers already trained who are presently working in the field. The greatest increment in providing additional health manpower services would logically be through increasing the efficienty of these people.

The unique background skills of Ann Lewis in occupational research and analysis have allowed us to do some exploration of a new means of attacking problems of utilization of health manpower. A pilot study was designed to determine whether a person who is technically competent in her own profession can be given limited training in task analysis sufficient to enable her to analyze the tasks being carried out in her hospital department. Experts in task analysis could, of course, be brought in from the outside at substantial cost to do this kind of study. However, a small number of experts, if they could be found, could not accomplish the huge job of working in California hospitals. Additionally, a study accomplished by institutional personnel themselves would be more likely to be implemented than one conducted by 'outsiders.'

Briefly, this pilot study conducted in the medical records department of a large medical cneter, showed that it was feasible to train a departmental person to do task analyses within that department, and that substantial changes in personnel utilization could be derived from that analysis.

Based upon these findings, an extensive project is now underway to study the largest hospital personnel group -- nursing service -- to develop training methods and techniques for these analyses. These techniques can then be used in training workers from other institutions so that they can apply them in their home institutions to achieve better utilization of personnel. This study is funded by Comprehensive Health Planning and is slated for completion in February, 1970.

Another utilization project is being conducted by the Council. Under a grant from California Regional Medical Programs, we are conducting an exploratory study on the use of personnel in selected private physicians'

offices. Some interesting leads for improved utilization of personnel in this group are developing on this project. The study will be completed this month, and the results will be summarized in our newsletter.

Thus, you can see that we are emphasizing research and study in accordance with the goals and objectives of the Council. We have firm plans to continue and to expand this function for which there is a very obvious need in California. We intend to point the way for needed research which should be carried by other agencies and groups since the size of the Council staff does not permit us to conduct these projects ourselves.

POLICIES AND METHODS

The Council has called for a fundamental state educational plan for health occupations. It has asked the Coordinating Council on Higher Education to develop a 'Master Plan for Higher Education in the Health Sciences.' We will continue to work toward this plan which is a real need in California.

We continually serve as resource persons for governmental and non-governmental persons and groups which are proposing changes in practices and procedures relating to health manpower. Thus, the Council wields considerable influence in improving the health manpower situation by working with existing agencies which have definite responsibility -- often under the law -- relating to health manpower.

COORDINATION

By coordination we mean a bringing together of people and agencies who are working on parts of common problems. We include here communication, wuch as providing information which others need in order to accomplish their work more effectively. Often we have found that individuals or agencies are working on activities that, unknown to them, others are already engaged in.

Operationally, we have found that the greatest service of the Council, to date, is in providing coordination among the many individuals, agencies and organizations involved with health manpower. Those of you who are working in this field realize how difficult it is to determine what is going on in manpower recruitment, training and utilization, and who is doing work in this field.

We are increasingly being used as a clearing-house for information by other agencies. Certainly we have a long way to go, but the Council is being recognized as the office for providing this service. It should be noted that we are doing a better job of this coordination in Northern California than in Southern California. We welcome suggestions on how we can improve service to the 'Southland.'

While it is very difficult to measure effectiveness in coordination, our reports to the Board on staff activities are heavily loaded with coordination activities. From the staff point of view, these services are among the highest priorities of what we do.

COUNSEL AND INFORMATION SERVICE

This category relates very closely to that of coordination. We are servicing numerous requests for information and providing counsel to persons who are working on specific manpower problems. Again, while the results of this service are difficult to measure, we feel that the impact of the Council is being spread quite widely and through the people who have the greatest effect on present and future health manpower.

The Council is moving ahead in achieving the goals for which it was established. A great deal has been accomplished for such a new agency. The professional staff is intentionally small -- partially, of course, due to budgetary limitations. As you know, I am the Council's Executive Director; and we also have the full-time services of Miss Ann Lewis through the courtesy of Council member Don Page and the California Department of Employment. It is only through Ann's talents that the Council has been able to plan and produce the research that has been completed and that is currently underway. This is a major contribution, and we gratefully acknowledge it.

The problems of health manpower are many and great. The topics chosen for the Conference discussion groups are those subjects which have the highest priority in requiring solution. Therefore, we hope that a very practical approach will be taken to proposing realistic solutions to these problems. Realism and practicality are necessary ingredients since the persons at this Conference are the ones who will be involved in achieving solutions. We all face real limitations on what we can do. But we can move toward solutions of problems, and we can begin the first steps here today.

The two staff persons serving the Council -- Ann Lewis and I -- are working hard on many manpower problems. But the problems facing us require more manpower than these two. In fact, all of us at this Conference are needed. Therefore, in setting up this Conference, we sought and received the assistance of knowledgeable staff from other organizations and agencies. They are providing staff service to many discussion groups, and we extend our appreciation to them.

We hope that the discussion groups will form the nucleus for continuing state-wide Task Forces to work toward solution of particular problems during the coming year, so that at next year's Conference we can report substantial progress in seven different areas -- the seven discussed here at this Conference.

In one respect, then, this is a do-it-yourself conference in that we are not, in the main, proposing recommendations that 'somebody ought to do'

something about. Rather, we are saying, 'What can we do to solve these problems?'

FINANCIAL REPORT

A brief note should be made of the Treasurer's report in the absence of the Treasurer. Dr. Harold Kay has served the Council as Treasurer since its formation. However, he recently became Chairman of the Council of the California Medical Association and, therefore, had to relinquish his duties as our Treasurer. His replacement as Treasurer is Dr. Malcolm Todd. Dr. Todd asked me to express his regrets in not being able to be here today. He is fulfilling an earlier commitment with a committee meeting on health manpower for the American Medical Association.

An annual audit has been completed for our fiscal year ending June 30. A copy of that audit will be included in the Conference report. Our total income was $79,500 and our total expense was $74,496, so you can see that we lived within a tight budget.

Our income comes from contributions of member agencies and from research grants. Of the approximately $64,000 contributed by member agencies, $25,000 came from the California Medical Association, and $25,000 from the California Hospital Association. Smaller amounts came from Blue Cross, the Kaiser Foundation, the dental societies, the California Nurses' Association, the Licensed Vocational Nurses' League, and others, several of which are present today.

The financial commitments made by these organizations when the Council was formed were for an initial three-year period. This three-year period expires on June 30, 1970. Therefore, the Council is presently considering methods of continuing funding. It seems likely that the basic budget of the Council will be provided by the member agencies. Your organization may wish to consider its place in the Council and its obligations to participate in its financing -- since no organization can survive without funds.

You will be contacted soon regarding the future financing plan for the Council.

Summarizing the Treasurer's report, we have lived within available income during the past year. A plan for continued financing of the Council is being worked on.

* * *

We want to express particular appreciation to the officers who served during the past year:

Dick Highsmith, as Chairman
Mrs. Peggy Bates, Vice-Chairman
Dr. Harold Kay, Treasurer
Jim Adair, Secretary
Mrs. Sylvia Marshall, Member-At-Large on the Executive Committee

I feel the Council has made major achievements during the past year. It faces a challenging new year. Your assistance today and during the coming year will help the Council accomplish the goals and objectives for which it was formed."

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HEALTH MANPOWER COUNCIL OF CALIFORNIA
(A Nonprofit California Corporation)

STATEMENT OF CASH RECEIPTS, DISBURSEMENTS AND FUND BALANCE

YEAR ENDED JUNE 30, 1969

CASH RECEIPTS:		
Contributions from participating agencies	$ 77,433	
Interest on savings account	1,355	
Conference registration fees	712	
Total Cash Receipts		$ 79,500
DISBURSEMENTS:		
Salaries	$ 34,728	
Payroll taxes and insurance	1,238	
Other employee benefits	4,117	
Auto leasing	1,870	
Consultants' fees	6,428	
Building occupancy--Rent and insurance	3,341	
Telephone	1,926	
Office equipment purchases	433	
Office supplies and expense	5,459	
Postage and shipping	586	
Travel expenses	10,061	
Meetings and conferences	2,543	
Legal and accounting	1,160	
Insurance and fidelity bond	606	
Total Disbursements		74,496
EXCESS, CASH RECEIPTS OVER DISBURSEMENTS		$ 5,004
FUND BALANCE:		
Beginning, July 1, 1968		36,775
Ending, June 31, 1969		$ 41,779

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INSTRUCTIONS TO GROUPS — Mrs. Sylvia Marshall

Mrs. Marshall reiterated the importance of each group developing tangible, realistic, and specific steps toward solving the problems assigned. The mechanics of operation and procedures were explained. Participants adjourned for work sessions in designated groups.

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GENERAL SESSION II

SUMMARY OF GROUP RECOMMENDATIONS — Ralph C. Kuhli, M.P.H.

Mr. Kuhli met breifly with the recorder from each group for a report of significant action. The following is his summary of those actions:

"It is brash to presume to summarize the results of discussions among experts such as are assembled here. I have attempted to find some common denominators among the groups which I will present before giving a summary of group deliverations.

It seems to me that you, individually, and the groups you represent, should now do better as we do five things:

1. Belief. When we look ahead at the problems, we may feel that there will be just more talk and inaction. However, if we look back a year, we will likely find that the problems we faced then have really been the subject of considerable action, and many problems have been resolved during this year. Therefore, we must believe that we can face problems and solve them during this coming year.

2. Cooperate. This word does not mean that you 'coo' while I 'operate.' Problems are solved through team effort which requires organization. No individual or single agency has the power to solve most of the problems facing us in health manpower, but together -- through cooperative effort -- we can solve the problems.

3. Concentrate. Most organizations try to tackle all of the problems presented to them. However, this cannot be done. We must concentrate our efforts. We need to identify what we really are; then be good at whatever that is. We need to identify our special role and competency and concentrate there.

4. Organize. There are three legs to the tripod of organization -- business and industry, government, and voluntary agencies. All three legs are needed for complete organization. We do not generally have the first group involved with us in working on health manpower problems. We need the competency and point of view of the business community.

5. Act. The issue is what I have learned here and what I am going to do now. What am I going to do differently as a result of what I have learned? This question needs to be answered directly by each one of us. The single word here is 'act,' i.e., do something. If we adopt this stance, we can say that this was an important conference; it was not just a lot of people sitting around talking.

   The printed proceedings of this conference will not be too important. The important thing is what happens to you and me and what happens in the organizations we represent. Let's do something.

If we follow through these five steps, this Conference will have been worthwhile, and we will have made a real contribution in solving health manpower problems.

Now, here is what the groups reported. These people are experts, and we should carefully consider their opinions.

GROUP I -- Health Manpower Data Collection and Interpretation

This group had especially expert participants. They saw little hope for simple solutions to the complex problems of meeting data needs. Improvement is needed in the relationship between data collections and user groups. An important consideration was the point of intervention, or making entry into the process, of data collection. There is a rapidly changing configuration of human resources in the health field which makes it difficult to collect data which has meaning in the changing system.

Group concerns included number, types, location, and training of personnel. A close-coupled relationship is required among all of these factors to make intelligent decisions. There are problems in definitions, philosophy, mode of operation, and many other

complicating factors which make for difficulty in collecting and interpreting data usefully. One-shot studies are quickly obsolete, and an on-going system of data collection should be developed. Perhaps we could interest business organizations in collecting information we need since the health groups represent potential markets for many products.

Two major recommendations were made:

1. That the Health Manpower Council of California maintain a directory, bibliography, source books, etc., on the manpower resources available to California. This should be published and distributed throughout California.

2. That employer groups be utilized in data collection and surveys.

GROUPS IIa and IIb -- Issues on Licensing of Health Manpower.

Both groups found major problems but also found it difficult to isolate -- and to agree on -- individual problems for which they could recommend steps toward solution. One group felt it could not determine what should be done. However, it was emphasized that it is necessary to continue to bring concerned groups together to continue discussing the problems as the step required before valid decisions could be made.

The other group was concerned with the problems of proliferation and fractionation of new occupations, and especially the pressure for new licensed categories. Rigidity, lack of mobility, exclusionism, lack of reciprocity, lack of equivalency, lack of articulation of occupation, standards, over-education, and lack of core curriculum, were problems discussed as affecting the whole sphere of licensing. This group recommended as the first step toward solution of the problems that:

> The Health Manpower Council should convene the two discussion groups on licensure as a Task Force with appropriate legal and legislative consultants to publicize a plan for licensure and certification (which would be developed by this Task Force) and then approach the legislature with the plan for its consideration and enactment.
>
> This group also recommended that schools should be urged to give some credit for experience and work training. Professional groups should work closely with schools in determining how this equivalency should be given.

GROUP III - Planning for Education in the Health Occupations.

This group included a number of educators who quickly moved to identify specific problems, such as organization for planning, bi-lingual training programs, humanistic training, understanding of the patient, sensitivity to different groups, cost of program development, need for lead time to develop educational programs, modified curricula for older people, examinations to determine qualified personnel, improved counseling and guidance, overemphasis on qualification for entrance to training programs, and too-early accreditation of new programs.

Solutions recommended included the following:

a. That members of this discussion group be an Education Task Force for the next year. (Consumer groups and minority groups should be represented).

b. That this group should be broadly concerned with patient care.

c. That a Health Manpower Council be developed in each labor market.

d. That the Council newsletter be used as a medium of communication on who is doing new work in education, including new curriculum development.

e. That the Council identify groups to develop and seek funds for new and innovative programs such as the one at Chabot College.

f. That the Council collect innovative ideas and identify sources of funding.

g. That next year's Conference include a success story on how to achieve planning for training, and how to involve people in planning.

GROUP IV -- Continuing Education for Health Manpower.

A major problem identified by this group is the possible mandatory requirement of continuing education for relicensure or recertification. Another problem is the availability of resources for continuing education. Motivation of workers to seek continuing education is also a problem.

The solutions proposed are the following:

a. That each profession should decide for itself

if continuing education should be mandatory.

b. That the Health Manpower Council work with the Health Manpower Subcommittee of Comprehensive Health Planning toward these ends: (1) Offer to help professions associations assess their needs, inventory continuing education activities, and (2) take responsibility for compilation and dissemination of information on continuing education in the health field.

c. That the community colleges and the state colleges should be used to a greater extent for continuing education for the health occupations, coordinating their efforts with the university.

d. That continuing education be planned on an interdisciplinary basis so that health workers learn each other's role in the interest of the health of the public.

GROUP V -- Recruitment, Screening, and Placement of Students.

Six specific problems were identified as follows:

1. Adequate compensation must be paid health workers in order to attract new people into the field.

2. Basic core curriculum should be developed for allied health and medical occupations.

3. An exploratory work-experience program should be developed.

4. Health occupations information should be made available in a concise, understandable, and accessible form.

5. Fragmented information should be pulled together.

6. Combined education and employment programs should be provided for persons who need to work part-time.

Some solutions were:

a. Collection and publication of data with conclusions to be reached by employers generally.

b. Approach the auxiliaries of the California Medical Association and the California Hospital Association for improved career recruitment programs.

c. Develop studies to determine the feasibility of employing part-time personnel.

GROUP VI -- Identifying Utilization Problems of Health Manpower.

Four major problems were identified:

1. Classifying the patients by acuity of illness creates new skill needs.

2. Financing mechanisms influence the delivery of care.

3. Health service programs are not coordinated.

4. Advancement opportunities are limited by a lack of evaluative instruments that can measure the improvement in a worker's skill obtained through education, training, and work-experience.

The recommendations for solution are:

a. The Health Manpower Council should develop a Task Force to demonstrate current inefficiencies.

b. There should be better communication with carriers and government to show their excessive cost of present systems.

c. A pilot program in the San Diego-Imperial area should be conducted to pursue the concept of registry, which was introudced by Ralph Kuhli, and its applicability to California. If this is not possible, then study the best way to allow personnel to achieve upward mobility.

GROUP VII -- Special Problems in Health Manpower -- Mental Health Manpower.

Specific problems were identified as follows:

1. The definition of psychiatric technicians under present legislation.

2. Refining the task-related approach to mental health manpower utilization rather than a "degree-discipline" orientation.

3. The deployment and substitute utilization of personnel where no workers now exist.

4. Developing techniques for preparing and utilizing indigenous health workers.

Recommended solutions were:

a. That the California Hospital Association and the California Society for Psychiatric Technicians get together to identify what manpower is needed.

b. That task forces at the local level identify local needs and develop creative ways of utilization, identify additional training needed to better utilize existing workers, and that communication take place in helping to develop training programs in community colleges.

c. That the on-going communication be continued and improved among the Health Manpower Council, Mental Health Committee of Comprehensive Health Planning and the Advisory Boards to local health mental health programs.

In concluding my participation in this Conference, I wish to emphasize the importance of believing in the process of working cooperatively together. It is much easier to work alone. But to cope with such enormous problems, we need to cooperate."

* * * *

In closing the Conference, Dr. Cullen expressed appreciation to the participants for their work in identifying specific problems and proposing solutions. "It is encouraging," he said, "that participants have volunteered to work on Task Forces on these problems. I have also been able to obtain some ideas from you on where to go to seek funds to carry out the recommendations made to the Council."

The Conference was adjourned.

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HEALTH MANPOWER COUNCIL OF CALIFORNIA

1969 HEALTH MANPOWER CONFERENCE

October 3-4, 1969

KONA KAI CLUB

SAN DIEGO

PROBLEM-ACTION DISCUSSION GROUPS

GROUP	TOPIC	CHAIRMAN
I	Health Manpower Data Collection and Interpretation	Mr. Baxter
IIa	Issues in Licensing of Health Manpower	Dr. MacLaggan
IIb	Issues in Licensing of Health Manpower	Dr. Rose
III	Planning for Education in the Health Occupations	Mr. Baldwin
IV	Continuing Education for Health Manpower	Dr. deTornyay
V	Recruitment, Screening & Placement of Students	Mr. Page
VI	Identifying Utilization Problems of Health Manpower	Mr. Williams
VII	Special Problems in Health Manpower -- Mental Health	Dr. Michener

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HEALTH MANPOWER CONFERENCE - 1969

DISCUSSION GUIDELINES

GROUP I - DATA

Specific Problems	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution.
Do not know what information is currently available (in various senses of "available").	Comprehensive Health Planning Unit in California?	Maintain directory, bibliography, indices, source books, etc. Conferences		
Personnel definitional problems: function vs. title; disagreement within disciplines.	No major effort known; may be a by-product of UCLA Allied Health Project.	Clarify occupational functions. Confer with professional organization to develop agreement.		
Personnel distribution needs	No major effort known			
Inadequate articulation between data users and data collectors	No group known			
Attrition data: Extent and reasons What problems of loss warrant attention?		Use of IBM, ITT, and other commercial systems to work on specific problems		

DISCUSSION GUIDELINES

GROUP II-a -- LICENSING

Specific Problems	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution
1. Certification vs. licensure vs. none	Each group State government Spec. CMA B/ME	1. Study by each group 2. Public discussion 3. Special Task Force of HMCC to study certification and licenses	MSP	
2. Ladder	CNA CLVNA B/NER			
3. Can't define our goals, our objectives				

DISCUSSION GUIDELINES

GROUP II-b -- LICENSING

Specific Problem	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution
LICENSURE: Proliferation & Fractionation		I would hope that each group would consider alternatives	We can study the question of licensure further -- we find it too complex to resolve at this time.	Health Manpower Council to convene discussion Groups IIa and IIb as a Task Force on Licensure with appropriate legal and legislative consultants to publicize the plan for licensure and certification this Task Force develops, and then approach the legislature with the plan as a proposal on licensure and certification for health manpower.
Rigidity, lack of mobility	The legislature, AMA, us, CNA, AHA, APTA, OT's, & other professional organizations.	No proliferation of licensing boards at this time. Start out with a basic core from which each group can go on.		
Exclusionism, lack of reciprocity	Nurses' national licensing exam., OT's & physicians' (18 State) exams, podiatry, ETS.	Overtraining is causing manpower shortages -- there should be sub-licensure certif.		
Lack of equivalency or credit, e.g., for corpsmen and people with long experience.	Ortho. Asst's Program at S.F. City College -- working on this?	Concentrate on accrediting schools, and accept people from accredited schools.		
Need for standards of competency	Individual organizations with registries and exams.	Licensure on a one-shot basis does not protect the public as well as periodic certification and recertification would do (very important).		

(Continued - next page)

DISCUSSION GUIDELINES

GROUP II-b -- LICENSING (Continued)

Specific Problem	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution
Pressures for over-education & aggrandisement				
*Lack of a core curriculum for mobility and economy of training	Medical schools (some, a few junior colleges and State colleges -- (Miss Clausen)? All schools of nursing. PT's and educators, pharmacists, some OT & PT training programs for continued therapist. Unions.			
*Education: (in summary) Part of the problem as well as part of the solution.	The Calif. Coordinating Council for Higher Ed. (?) Junior colleges (?) State college programs -- master degree in nursing.		Professional schools, junior colleges, state colleges, Calif. Coordinating Council on Higher Ed.	Inform schools that some efforts should be made to give some credit in formal programs for previous education, experience, foreign graduates & corpsman training -- criteria to be established by educators in concurrence with people from the discipline in question.

DISCUSSION GUIDELINES

GROUP III -- EDUCATION

Specific Problem	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution.
Problem Areas 1. Organization for Planning a. Bi-lingual training; humanistic training; warmth & understanding of the patients. Sensitivity to all groups. b. Cost of program development -- need for lead time c. Committed participation. Organizational plan for training d. Planning for relevance e. Need guidelines for doing this.	Labor market areas -- State, S.F., L.A. Many councils throughout State. All professional groups. Assn. of Schools of Allied Health (Nat'l). Coord. Council--San Diego, S.F. Community Action Councils Inner City Groups	Participation needs to include all interested Organization of more local or area councils Actively recruit minority representatives Set up meetings within the minority environment Professionals work together to define common problems	1. State Health Manpower Council. 2. People present at this meeting. 3. Include or work with Comprehensive Health Planning organizations	To ensure educational planning for Medical and Dental Allied Health, we recommend that: a. Members of this group work as Interim Committee for next year. Be certain that minority groups are represented. Be certain that consumer groups are represented. Broadly representative; concerned with patient care. That Health Manpower Council be developed in each labor market area.
		(Continued - next page)		

DISCUSSION GUIDELINES

GROUP III -- EDUCATION (Continued)

Specific Problem	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution.
2. Curriculum Development & Revision a. Modified programs (1) for older people (2) exam to determine qualified professional b. More knowledge about counseling & guidance c. Over-emphasis on entrance requirements d. Too early accreditation e. Creative new innovative programs. Goals for 5 or 10 years from now.	3 segments of higher education. Nat'l Technical Advisory Allied Health Professions Group -- UCLA (Task Analysis) Groups such as Nat'l Study on Pediatrics --Harvard (Dr. Yankhauser) Comp. Health Plng--12 counties--Chico College PHS--Health Manpower Development Grant Funds Comm. of Curriculum Construction--CJCA Comm. of Vocational Construction--CJCA	Encourage professional organizations and teams of health workers together to develop a curriculum. Encourage any new group that is grying to develop a curriculum--to come to the Health Manpower Council for consultation. Encourage professional organizations to do task analysis in comparison with licensing requirements.	Working committee from this group. From this group: Volunteer Task Force for HMCC-- M. Barela Dick Grant M. Wilson J. Clawson R. Sumner N. Woodward Ask Mrs. Wilson L. Baldwin to be Council Liaison	Use Newsletter as communicator of "Who's doing it now" in curriculum development. Council identify group to develop an innovative program and seek funds for support such as the one at Chabot--Glenis Wilson (behavioral basis). Council collect data on innovative ideas. Council identify sources of funding.
3. Program Implementation and Evaluation Over-training Task Analysis Licensing; Certification				

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DISCUSSION GUIDELINES

GROUP IV -- CONTINUING EDUCATION

Specific Problem	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution
Mandatory Con't Educ. for Relicensure or Recertification	All professional associations Legislature			Difference in professional groups are such that each profession should decide for itself if it should be mandatory or not for its own group. May be necessary for non-members of these organizations. The Health Manpower Council work in concert with the Comprehensive Health Planning subcommittee on Health Manpower toward these ends: 1. Offer to help professional associations assess their needs, inventory, available continuing educ. activities. 2. Take responsibility of coordination and dissemination of information of C.E. in the health fields.
Resources	Professional Associations Employing Agencies Educational Institutions Voluntary Health Agencies Commercial Vendors Government Agencies, i.e., USPHS			
Motivation of Workers to seek C.E.	Professional Associations Employers	Better Courses Higher Rewards		

(Continued - next page)

DISCUSSION GUIDELINES

GROUP IV -- CONTINUING EDUCATION (Continued)

Specific Problem	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution
				The community colleges and state colleges should be utilized to a greater extent for Cont. Educ. of the health occupations, coordinating their efforts with the university. That Cont. Educ. be on a more interdisciplinary basis so that Health workers understand one another's role better in the interest of the health of the public.

DISCUSSION GUIDELINES

GROUP V -- STUDENTS

Specific Problem	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution
1. Adequate compensation	? (statistics available)	Publish comparative figures for other occupations	HMPC sub-committee	Publication of data with conclusions to be reached by employers generally.
2. Basic core curriculum for Medical & Allied Health occupations	Several -- fragmentary	Borrow existing or establish new basic core curriculum for medical occupations	Grant or contract basis through HMPC	
3. Exploratory work experience program	Schools & some community health people	Broad dissemination of means of exposing students to work experience for credit.	HMPC sub-committee	
4. Making extensive health occupation information available in concise and accessible form.	San Diego schools, Dept. of Employment, & others	Study project view and similar projects for feasibility	HMPC sub-committee	Approach CMA and CHA auxiliaries.
5. Fragmented information	?	Secure one central source of information in State on health careers	HMC, CMA, & CHA to implement existing structures into one authoritative source material.	
6. Availability of employees who could work part-time	?	Questionnaire through P & VS to determine availability for part-time work.		Utilization studies will need to be conducted to determine feasibility of employing part-time personnel.

DISCUSSION GUIDELINES

GROUP VI -- UTILIZATION

Specific Problem	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution
1. Division of patients by acuity of illness creates new skill needs				
2. Financing mechanisms influence delivery of care		Change financial restrictions of insurance carriers and government to permit proper utilization of personnel and facilities.	Task Force HMC plus state-wide organizations	1. HMC develop data with Task Force to demonstrate current inefficiencies. 2. Communicate with carriers and government to show them excessive costs of present systems.
3. Health Service Programs are not coordinated	CHP & RMP	Two organizations plus mental health groups continue efforts with	CHP, RMP & Mental Health Groups & HMC	Establish pilot programs in San D[illegible]-Imperial area
4. Advancement opportunities are limited by the need for measuring devices of education, training, & work experience.		Develop measurement tools--practical & theoretical--or a structure for such tools which will be accepted by educational institutions. Expand acceptance of credit for work, training, and/or education achieved in a variety of settings.	Task Force appointed by HMC	Pursue with Ralph Kuhli concept of registry--if applicable adopt California--if not, study best way to continue to allow health personnel to achieve upward mobility.

DISCUSSION GUIDELINES

GROUP VII - MENTAL HEALTH MANPOWER

Specific Problem	Who is working on problem now?	What can be done to solve these problems?	Who can do it?	Recommend specific steps toward solution
1. Definition of Psych. Tech. under current legislation	Licensing Board (BVN & PT Examiners) CSPD CHA	Redefinition and clarification of law	Legislature	CHA & CSPT "get together" to identify what is needed
2. Defining a task orientation to Mental Health Manpower Utilization rather than a degree-discipline orientation (equally applicable to all health manpower)	Community Colleges (beginning to) D.M.H. (beginning to)	Cooperative action of educ. & service to define observable, measurable behaviour of mental health workers. Commitment of service agencies to utilize. Define which jobs need this definition.	Education Mental Health agencies Comprehensive Hlth. Planning Program) Personnel) "people" in DMH & comm. agencies.	Task Forces at local level to identify local needs and develop creative methods of utilization. Identify additional training needed to better utilize existing workers. Communication between DMH & Comm. Colls. in helping develop programs (for PD's) in Comm. Colls.
Other Problems 1. Deployment & substitute utilization where no workers now exist. 2. Developing techniques for preparing & utilizing indigenous workers.				On-going communication between: (1) Health Manpower Council, (2) Mental Health Comm. of Comprehensive Health Planning, (3) Advisory Boards to local programs in Mental Health.

HEALTH MANPOWER CONFERENCE

SAN DIEGO

October 3, 4, 1969

REGISTRANTS

NAME	CITY	AFFILIATION
ABBOTT, Ellen M.	La Mesa	CLN & Grossmont Nursing Education
ADKINS, Hazel		Calif. Chapters, American Physical Therapy Assn.
AMADOR, Richard S.	Los Angeles	Community & Human Resources Agency
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ANDERSON, Dorothy	Alhambra	Calif. Regional Medical Programs, Area V (USC School of Medicine)
ANDERSON, Gustav D.	San Francisco	Health Professions Council of San Francisco
BALDWIN, Leland	Sacramento	California Community Colleges
BARHAM, Virginia, R.N., Ed.D.	San Francisco	Nursing Education Consultant, Board of Nursing Education & Nurse Registration
BAXTER, A.W.	Berkeley	President; Baxter, McDonald & Co.
BELLENGER, Joseph C.	Los Gatos	Allied Health Manpower Council of Santa Clara County
BESS, Dorothy	Los Angeles	Instructor, Radiologic Technology
BINE, Rene, M.D.	San Francisco	California Heart Assn.

1969 Health Manpower Conference
Registrants (continued)

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BRINEY, Kenneth L., Ph.D.	Orinda	Executive Director, Health Manpower Council
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BROWN, Lillian E.	Orange	Orange County Medical Center
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BUGGY, Michael R., R.N.	Sacramento	Executive Secretary, Calif. Board of Nursing Educ. & Nurse Registration
CAREY, Michael C. J.	Eureka	Norcoa Health, Inc.
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CHIPMAN, Wallace B.	Oakland	California Health Power Council
CLARK, D. W., M.D.	San Jose	CMA - Council
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COATS, Walter G.	San Diego	San Diego Community Colleges

1969 Health Manpower Conference
Registrants (continued)

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CONOVER, Robert	San Francisco	American Cancer Society
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CORRIGAN, F. Eleanor, D.P.M.	National City	San Diego Div. of Calif. Podiatry Assn.
COVELL, Ruth, M.D.	La Jolla	UCSD School of Medicine
CROMWELL, Florence S.	Pasadena	American Occupational Therapy Assn.
CULLEN, Stuart C., M.D.	San Francisco	Dean, School of Medicine, Univ. of Calif., San Francisco Medical Center
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DELLEGAR, W. E.	El Cajon	Grossmont College
de TORNYAY, Rheba, R.N., Ed.D.	San Francisco	California Nurses' Assn.
DIMMICK, Robert L.	San Francisco	Center for Advanced Medical Technology
DOBROW, Brian	Stockton	Golden Empire Regional Comprehensive Health Council
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1969 Health Manpower Conference
Registrants (continued)

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FULLER, Kay D., R.N.	Alhambra	Calif. Regional Medical Programs, Area V (USC School of Medicine)
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GETZOFF, Peter	Los Angeles	Greater Los Angeles Urban Coalition
GIBSON, Harland	Sacramento	Comprehensive Health Planning
GIBSON, Thomas A. (Mrs.)	Upland	Calif. Medical Assn., Women's Auxiliary, Chairman of State Health Careers
GIRD, Willa Mae	San Diego	Licensed Vocational Nurses' League of Calif., San Diego --Dist. #2
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1969 Health Manpower Conference
Registrants (continued)

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GOINS, Pearl M.	Rialto	
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HATCHER, C. M.	El Cajon	Grossmont College
HIGHSMITH, Richard	Oakland	Samuel Merritt Hospital
HINTERMANN, Betty	Orinda	Council Publcity Consultant
HOERMANN, Siegfried A.	Washington, D.C.	Director, Health Resources Statistics, National Center Health Statistics
HOOVER, David B.	Bethesda, Md.	Chief, Manpower Resources Branch, Division of Allied Health Manpower
HOPE, Ann	San Francisco	California Heart Assn.
HUBBARD, Jack	Sacramento	Dept. of Mental Hygiene, Bureau of Training
HUEBNER, Sharon	San Diego	Society of Radiologic Tech.
JACKSON, Robert L.	Sacramento	State Health Planning Council
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JOHNS, Robert O., D.P.M.	San Francisco	California Podiatry Assn.
JOHNSON, Alice N., R.N.	San Diego	Director of Nursing, Euclid Convalescent Center
KUHLI, Ralph	Chicago, Ill.	American Medical Assn.
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1969 Health Manpower Conference
Registrants (continued)

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LINVILLE, Clifton	Fresno	Fresno Community Hospital
MAC LAGGEN, James, M.D.	Sacramento	State Board of Medical Examiners
MAHON, Paul	Sacramento	California Hospital Assn.
MARSHALL, Sylvia	Encino	Conference Planning Chairman
MC DONALD, Patricia A.	Los Angeles	Southern California Assn. of Medical Record Librarians
MEEK, Doris A.	San Diego	San Diego State College, San Diego Comprehensive Health Manpower
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MILLER, Eugene, M.D.	San Francisco	California Medical Assn.
MITCHELL, Katherine G.	Sacramento	Sacramento Medical Auxiliary
MONTAGUE, Ernest, Dr.	Monterey	HUMPRC, Div. No. 3
MOORE, John R.	SanDiego	University Hospital
MOORE, Thomas G., Jr.	Burlingame	Calif. Council for Health Plan Alternatives
MURPHY, Constance M.	Sacramento	Coordinator, Volunteer Services Div., California Hospital Assn.

1969 Health Manpower Conference
Registrants (continued)

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O'FARRELL, Tom	Chicago, Ill.	Assoc. Dir., Hospital Continuing Educ. Project; Hospital Research & Educ., American Hospital Assn.
ORCHARD, Margaret J.	Los Angeles	Southern California Comprehensive Health Planning Council
OURSLAND, Leon E.	San Diego	Chairman, Council on Dental Auxiliary Relations, Southern Calif. Dental Assn.
PACQUET, Beverly	Long Beach	Memorial Hospital of Long Beach
PAGE, Donald	Sacramento	Chief, Employment Services, California Department of Employment
PANSKY, Louis J.	San Francisco	Program of Continuing Educ. in Public Health, Western Regional Office, A.P.H.A.
PEARSON, Gertrude R., R.T., FASRT	Los Angeles	Chairman, Radiologic Technology Dept., Los Angeles City College
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PENNINGTON, Barbara	Chula Vista	S.D. District of Calif., Soc. of Radiologic Tech.
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PRICE, Derek W.	La Jolla	Regional Medical Programs, Calif. Area VII

1969 Health Manpower Conference
Registrants (continued)

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RENFRO, Dean	Laguna Beach	California Nursing Home Assn.
ROBERTS, Richard L., R.S.	San Bernardino	California Assn. of Sanitarians
ROSE, E. Kash, M.D.	Napa	CMA Council
ST. DENIS, Frank	Los Angeles	Hospital Council of Southern California
SASULY, Richard	San Francisco	Calif. Comm. on Regional Medical Programs
SATHER, Richard E.	La Mesa	California Sssn. of Medical Technologists
SAUERS, Sr. Helen Marie, R.N.	Chula Vista	Southwestern College
SCHMIDT, Edna		Calif. Chapters - American Physical Therapy Assn.
SCHWARZ, Feliz	San Francisco	California Medical Assn.
SENTERS, Josephine	Seattle, Wash.	Washington State Health Manpower Project
SIEGEL, Eugene A.	San Diego	Comprehensive Health Planning Assn. of San Diego & Imperial Counties
SILVER, William J.	San Francisco	Mt. Zion Hospital & Medical Center
SKIBA, Maurean	Los Angeles	California Nurses' Assn.
STEVENS, Berenice	Oakland	California Assn. Med. Lab. Technologists
STEWART, Paula	Washington, D.C.	Health Manpower Statistics, Nat'l Center for Health Stat., U.S. Dept. H.E.W.
STOLCIS, Eileen	Long Beach	Memorial Hospital of Long Beach; Assn. of Med. Record Librarians

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Registrants (continued)

NAME	CITY	AFFILIATION
STREET, Alison	San Diego	Calif. Assn. Med. Lab. Technologists
STROTHER, Charles M., Dr.	Glendale	Chairman, Council on Dental Education; Southern Calif. Dental Assn.
SUMNER, Ruth, Ph.D.	San Francisco	Health Manpower, P.H.S., H.E.W. Region IX
TERRY, Daniel W., M.D.	Sacramento	Sacramento County Medical Society
THOMPSON, Opal	El Cajon	Grossmont College
TOLEN, Carol	Mt. View	Northern Calif. State Dental Hygienists Assn.
WARD, Phoebe T.	Temple City	President, Southern Calif. Occupational Therapy Assn.
WELLES, Carlotta, OTR	Pasadena	Los Angeles City College
WILLETT, David E.	San Francisco	Hassard, Bonnington, Rogers & Huber
WILLIAMS, Russell	Pasadena	Huntington Memorial Hospital
WILSON, Glenys	San Leandro	Chabot College
WILSON, Mary	San Diego	Mercy College of Nursing
WONG, John C.	Columbia, Mo.	
WOOD, Beverly	Berkeley	State Dept. of Public Health, New Careers
WOODWARD, Nell M.	Orange	Orange Coast College
YEE, Virginia	San Francisco	Board of Nursing Education & Nurse Registration
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HEALTH MANPOWER CONFERENCE

SAN DIEGO

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GROUP I -- DATA

REGISTRANTS

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CLARK, D. W., M.D.	San Jose	CMA - Council
CROMWELL, Florence S.	Pasadena	American Occupational Therapy Assn.
GETZOFF, Peter	Los Angeles	Greater Los Angeles Urban Coalition
GIRD, Willa Mae	San Diego	Licensed Vocational Nurses' League of Calif., San Diego --Dist. #2
GLEASON, Jacqueline	Washington, D.C.	Chief, Health Manpower Statistics, Nat'l Center for Health Statistics, U.S. Dept. H.E.W. Region IX
GOINS, Leonard	Rialto	
GOINS, Pearl M.	Rialto	
HOERMANN, Siegfried A.	Washington, D.C.	Director, Health Resources Statistics, Nat'l Center Health Statistics
HOOVER, David B.	Bethesda, Md.	Chief, Manpower Resources Branch, Div. Allied Health Manpower

Group I - Data
Registrants (continued)

NAME	CITY	AFFILIATION
JACOBSEN, Richard F.	San Diego	Comprehensive Health Planning Assn. of San Diego & Imperial Counties
LEIGHTON, Eric	San Francisco	Director, California Health Data Corp.
MC DONALD, Patricia A.	Los Angeles	Southern Calif. Assn. of Medical Record Librarians
PENNELL, Maryland Y.	Bethesda, Md.	Special Assistant to Director, Div. Allied Health Manpower
PENNINGTON, Barbara	Chula Vista	S.D. District of Calif. Society of Radiologic Tech.
SENIERS, Josephine	Seattle, Wash.	Washington State Health Manpower Project
STREET, Alison	San Diego	Calif. Assn. of Medical Laboratory Technologists
TERRY, Daniel W., M.D.	Sacramento	Sacramento County Medical Society
WONG, John C.	Columbia, Mo.	
WOOD, Beverly	Berkeley	State Dept. of Public Health, New Careers

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GROUP II-a -- LICENSING REGISTRANTS

NAME	CITY	AFFILIATION
ABBOTT, Ellen M.	La Mesa	CLN & Grossmont Nursing Education Program
BLACK, Noel A.	Sacramento	State Dept. of Professional & Vocational Standards
BUCKLEY, Dorothy L.	Fullerton	Fullerton Junior College
BUGGY, Michael R., R.N.	Sacramento	Executive Secretary, Calif. Board of Nursing Education & Nurse Registration
CHIPMAN, Wallace B.	Oakland	California Health Power Council
COLVIN, Thelma	San Diego	California Medical Assistants Assn.
CORRIGAN, F. Eleanor, D.P.M.	National City	San Diego Div. of Calif. Podiatry Assn.
FAKKEMA, Laverne	Berkeley	Calif. State Dept. of Public Health
FERRIS, F. Lou	San Diego	San Diego Community College
FRENCH, Jean G.	Berkeley	School of Public Health, University of California
GAGE, Barbara	Temple City	Southern California Occupational Therapy Assn.
JACKSON, Robert L.	Sacramento	State Health Planning Council
MAC LAGGEN, James, M.D.	Sacramento	State Board of Medical Examiners
MILLER, Eugene, M.D.	San Francisco	California Medical Assn.

Group II-a -- Licensing
Registrants (continued)

NAME	CITY	AFFILIATION
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PLAPPERT, Elma	Oakland	T.B. & Respiratory Disease Assn. of Calif.
ST. DENIS, Frank	Los Angeles	Hospital Council of Southern California
WILLETT, David E.	San Francisco	Hassard, Bonnington, Rogers & Huber

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GROUP II-b -- LICENSING REGISTRANTS

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CHEEVER, Jack		Calif. Chapters - American Physical Therapy Assn.
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CORBETT, Myron R.	San Jose	Allied Health Manpower Council of Santa Clara Co.
EGELSTON, Martin	Chicago, Ill.	American Hospital Assn.
FIELDS, Joseph	Chula Vista	California Podiatry Assn.
FULLER, Kay D., R.N.	Alhambra	Calif. Reg'l Medical Programs, Area V (USC School of Medicine)
JOHNS, Robert O., D.P.M.	San Francisco	Calif. Podiatry Assn.
JOHNSON, Alice N., R.N.	San Diego	Director of Nursing, Euclid Convalescent Center
MELONE, Frank C.	Ontario	California Medical Assn.
ROSE, E. Kash, M.D.	Napa	CMA Council
SATHER, Richard E.	La Mesa	Calif. Association of Medical Technologists
SAUERS, Sr. Helen Marie, R.N.	Chula Vista	Southwestern College
SCHWARZ, Felix	San Francisco	California Medical Assn.
TOLEN, Carol	Mountain View	Northern California State Dental Hygienists Assn.

Group II-b -- Licensing
Registrants (continued)

NAME	CITY	AFFILIATION
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YEE, Virginia	San Francisco	Board of Nursing Education & Nurse Registration

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October 3, 4, 1969

GROUP III -- EDUCATION REGISTRANTS

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BALDWIN, Leland	Sacramento	California Community Colleges
BELLENGER, Joseph C.	Los Gatos	Allied Health Manpower Council of Santa Clara Co.
BRODY, Barbara	La Jolla	California Regional Medical Programs, Area VII
CLAWSON, Jean M.	Sacramento	California Community Colleges
COLLIER, Tom	Sacramento	California Hospital Assn.
CONOVER, Robert	San Francisco	American Cancer Society
COVELL, Ruth, M.D.	La Jolla	UCSD School of Medicine
CULLEN, Stuart C., M.D.	San Francisco	Dean, School of Medicine, San Francisco Medical Center, University of California
ERICKSON, Carl A., M.D.	Pasadena	American Academy of Pediatrics
GLENN, Richard A.	Ventura	Ventura College
GRANT, Richard H.	San Diego	San Diego State College
HUEBNER, Sharon	San Diego	Society of Radiologic Technologists
MEEK, Doris A.	San Diego	San Diego Comprehensive Health Manpower, San Diego State College

Group III -- Education
Registrants (continued)

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RENFRO, Dean	Laguna Beach	California Nursing Home Association
SCHMIDT, Edna		California Chapters - Americal Physical Therapy Assn.
SILVER, William J.	San Francisco	Mt. Zion Hospital and Medical Center
SUMNER, Ruth, Ph.D.	San Francisco	Health Manpower, Public Health Service, U.S. Dept. of H.E.W., Region IX
THOMPSON, Opal	El Cajon	Grossmont College
WELLES, Carlotta, OTR	Pasadena	Los Angeles City College
WILSON, Mary	San Diego	Mercy College of Nursing
WOODWARD, Nell M.	Orange	Orange Coast College

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GROUP IV -- CONTINUING EDUCATION REGISTRANTS

NAME	CITY	AFFILIATION
ADKINS, Hazel		Calif. Chapters - American Physical Therapy Assn.
BINE, Rene, M.D.	San Francisco	California Heart Assn.
BRAMSON, Robert M., Ph.D.	Berkeley	State of California, Dept. of Public Health
DE TORNYAY, Mrs. Rheba, R.N., Ed.D.	San Francisco	California Nurses' Assn.
DIMMICK, Robert L.	San Francisco	Center for Advanced Medical Technology
HARRIS, Gordon F., D.D.S.	Los Angeles	California Dental Assn.
HOPE, Ann	San Francisco	California Heart Assn.
KUZMAN, William J., Dr.	San Diego	California Heart Assn.
MOORE, John R.	San Diego	University Hospital
O'FARRELL, Tom	Chicago, Ill.	Associate Director, Hospital Cont. Educ. Project; Hospital Research & Educ., American Hospital Assn.
PANSKY, Louis J.	San Francisco	Program of Continuing Educ. in Public Health, Western Regional Office, A.P.H.A.
STEVENS, Berenice	Oakland	Calif. Assn. Med. Lab. Technologists
STROTHER, Charles M., Dr.	Glendale	Chairman, Council on Dental Educ., So. Calif. Dental Assn.

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GROUP V -- STUDENTS REGISTRANTS

NAME	CITY	AFFILIATION
BESS, Dorothy	Los Angeles	Instructor, Radiologic Technology
BOSTICK, Warren L., M.D.	Irvine	Dean, California College of Medicine, University of California
DAVIDSON, Jan	Indianapolis	Indiana Health Careers, Inc.
DELLEGAR, W. E.	El Cajon	Grossmont College
DURHAM, Bryan		Calif. Chapters - American Physical Therapy Assn.
GIBSON, Mrs. Thomas A.	Upland	Calif. Medical Assn. Women's Auxiliary, Chairman of State Health Careers
HATCHER, C.M.	El Cajon	Grossmont College
MITCHELL, Katherine G.	Sacramento	Sacramento Medical Auxiliary
MURPHY, Constance M.	Sacramento	Coordinator, Volunteer Services Division, Calif. Hospital Assn.
PAGE, Donald	Sacramento	Chief, Employment Services, Calif. Dept. of Employment
SIEGEL, Eugene A.	San Diego	Comprehensive Health Planning Assn. of San Diego & Imperial Counties
SKIBA, Maurean	Los Angeles	California Nurses' Assn.
STOLCIS, Eileen	Long Beach	Memorial Hospital of Long Beach, Calif. Assn. of Med. Record Librarians

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GROUP VI -- UTILIZATION

REGISTRANTS

NAME	CITY	AFFILIATION
ANDERSON, Dorothy	Alhambra	Calif. Regional Medical Programs, Area V (USC School of Medicine)
BARHAM, Virginia, R.N., Ed.D.	San Francisco	Nursing Education Consultant, Board of Nursing Education & Nurse Registration
CAREY, Michael C. J.	Eureka	Norcoa Health, Inc.
CHILDS, Alfred W.	Berkeley	School of Public Health, University of California
GIBSON, Harland	Sacramento	Comprehensive Health Planning
MAHON, Paul	Sacramento	California Hospital Assn.
MOORE, Thomas G., Jr.	Burlingame	Calif. Council for Health Plan Alternatives
NELSON, Janice, R.P.T.	Long Beach	Chief, Physical Therapy, Memorial Hospital of Long Beach
ORCHARD, Margaret J.	Los Angeles	Southern California Comprehensive Health Planning Council
OURSLAND, Leon E.	San Diego	Chairman, Council on Dental Auxiliary Relations; Southern California Dental Assn.
PACQUET, Beverly	Long Beach	Memorial Hospital of Long Beach
PRICE, Derek W.	La Jolla	Regional Medical Programs, Calif. Area VII

Group VI -- Utilization
Registrants (continued)

NAME	CITY	AFFILIATION
ROBERTS, Richard L., R.S.	San Bernardino	Calif. Assn. of Sanitarians
SASULY, Richard	San Francisco	Calif. Coordinating Commission for Regional Medical Programs
WILLIAMS, Russell	Pasadena	Administrator, Huntington Memorial Hospital
ZORN, Gunther	Sacramento	Dept. of Mental Hygiene, Program Review Unit

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GROUP VII -- MENTAL HEALTH MANPOWER REGISTRANTS

NAME	CITY	AFFILIATION
DOBROW, Brian	Stockton	Golden Empire Regional Comprehensive Health Council
GALIONI, E. F., M.D.	Sacramento	California Dept. of Mental Hygiene
HUBBARD, Jack	Sacramento	Dept. of Mental Hygiene, Bureau of Training
LAYMAN, Richard P.	San Diego	Comprehensive Health Planning Assn. of San Diego & Imperial Counties
MARSHALL, Sylvia	Encino	Conference Planning Chairman
MICHENER, David P., M.D.	Sacramento	Dept. of Mental Hygiene
WILSON, Mrs. Glenys	San Leandro	Chabot College

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GROUP NOT DESIGNATED — REGISTRANTS

NAME	CITY	AFFILIATION
BRINEY, Kenneth L., Ph.D.	Orinda	Executive Director, Health Manpower Council
COMBS, Robert C., M.D.	Irvine	U.C. Reg'l Medical Programs, Area VIII
FOX, Hazel, R.N.	Oakland	California Licensed Vocational Nurses' Assn.
FREDERICK, Lois F.	Torrance	California LVN Assn., Inc.
HIGHSMITH, Richard	Oakland	Administrator, Samuel Merritt Hospital
HINTERMANN, Betty		Council Publicity Consultant
KUHLI, Ralph	Chicago, Ill.	American Medical Assn.
LEWIS. Ann	Orinda	Consultant, Health Manpower Council
LINVILLE, Clifton	Fresno	Administrator, Fresno Community Hospital