STUDY OF THE PERCEPTION OF CERTIFICATION VERSUS LICENSURE AS VIEWED BY MEDICAL PERSONNEL IN NORTHEAST OKLAHOMA

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CHAPTER I

INTRODUCTION

Historically, nursing type of skills date from the 1850-1860s. According to Smith (18) the Registered Nurse was first credentialed by licensure in the State of Oklahoma in 1909, the Licensed Practical Nurse was first established in the United States in 1893. However, the practical nurse was not licensed in Oklahoma until 1953.

Another member of the paramedical team assisting the doctor in the "nursing" care of the patient is the Certified Medical Assistant (CMA). The parent organization, the American Association of Medical Assistants (AAMA), began in 1957. However, the first certification examination was not administered until 1963 (1). Therefore, the Certified Medical Assistant is the newest member of the nursing team.

The education acquired by the Certified Medical Assistant who has completed a two-year accredited medical assistant program encompasses a wide variety of job specialties that include nursing responsibilities. These skills enable the CMA to function in either the front (administrative tasks) or back (clinical tasks) office of a physician. Since these skills encompass many nursing tasks, this education should also prepare the Certified Medical Assistant to function in

numerous positions within the hospital. Job descriptions, from hospitals in the Tulsa area, for the Registered Nurse (RN) and the Licensed Practical Nurse (LPN) include many of the same skills the CMA is capable of performing.

The hospital and physician are legally responsible for all employees (11). Therefore, these health professionals are concerned about the credentialing of their employee. Research indicates two methods of credentialing are most accepted today in the United States (16). These are licensure and certification. Many allied health occupations believe the licensure endorsement is a "measure of ability." That is, since licensure endorsement is granted by state statutes this method must provide the best protection from unsafe practices for the patient (11).

Statement of the Problem

The specific problem of this study was the lack of information or understanding by medical personnel regarding the task-performing abilities of the Certified Medical Assistant and licensed nursing personnel.

Purpose of the Study

The purpose of this study was to identify how selected medical personnel perceive the different task-performing abilities of licensed versus certified allied health personnel in the State of Oklahoma. This study sought to answer the following questions:

1. Do family practitioners (medical doctors, M.D.; and osteopathic doctors, D.O.) perceive differences in the task-performing ability of certification versus licensure as identified by tasks designated to medical personnel holding differing titles?

2. Do hospital administrators perceive differences in the task-performing ability of certification versus licensure as identified by tasks designated to medical personnel holding differing titles?

3. Do directors of nursing services perceive differences in the task-performing ability of certification versus licensure as identified by tasks designated to medical personnel holding differing titles?

4. Does the size of the community affect the perception of the family practitioner with regard to the task-performing abilities of licensed versus certified allied health personnel?

5. Does the size of the community affect the perception of the hospital administrator with regard to the task performing abilities of licensed versus certified allied health personnel?

6. Does the size of the community affect the perception of the directors of nursing services with regard to the task-performing abilities of licensed versus certified allied health personnel?

Need for the Study

Recent newspaper and magazine articles as well as television coverage indicate a rise of malpractice claims in the United States. Physicians and hospitals are very conscious of the "delegation" of tasks to the allied health personnel. Physicians and hospitals need to be protected by the laws of the state in which they live (11).

The Medical Practice Acts differ in each state. The state of Oklahoma has amended the Medical Practice Acts to authorize broadened delegation of function. That is, the Oklahoma statute authorizes rendering of services by the health care team member as directed by the physician. The services must be rendered under the direct supervision and control of a licensed physician (19).

Research by Hixon (8) indicates a shortage of nursing personnel. Many of the advertisements in the state of Oklahoma requiring clinical responsibilities indicate the need for a Registered Nurse or Licensed Practical Nurse. These tasks, especially in the physician's office, often incorporate skills the RN or LPN have not obtained in his/her education. The education obtained by the Associate Degree Nurse or Licensed Practical Nurse in school is primarily aimed at "bedside patient care." The CMA, graduate of a two-year accredited program, receives training in clinical skills which encompass some of the same skills obtained by the RN, LPN, Medical Laboratory Technician, Electrocardiograph technician as well as Radiology Technician programs.

With the shortage of nursing personnel, the skills of a Certified Medical Assistant can be incorporated within the medical offices as well as many positions within the hospital. Nursing personnel (RN and LPN) could be released to perform the tasks that only they would be qualified to do, which include bedside patient care. Buzek (5) in 1971 suggested a better distribution of traditional responsibilities to maximize the output of each participant in the health care team. This distribution of tasks to health personnel would help alleviate shortages in critical areas.

Assumptions Basic to the Study

A major assumption is that medical personnel in the selected cities of Oklahoma responded honestly to the questionnaire with regard to the delegation of tasks to the appropriate medical personnel and were representative of the majority of medical personnel they represent.

Limitations of the Study

This study was limited to hospital administrators and directors of nursing services in selected cities in Northeast Oklahoma. Further limitations were imposed by the selection of practicing family practitioners (M.D. and D.O.) in selected cities in Northeast Oklahoma. For purposes of this study, the skills of the Certified Medical Assistant were limited to clinical tasks. The education of the RN and LPN do not encompass front office (administrative) tasks.

Definition of Terms

The following definitions help to clarify this report.

AAMA - American Association of Medical Assistants.

AMA - American Medical Association.

Accreditation - The process whereby a private, nongovernmental agency or association grants public recognition to an institution or specialized program of study which meets certain established qualifications and educational standards, as determined through initial and subsequent periodic evaluation.

Allied Health Personnel - A broad category of personnel which includes professional and supporting workers in the fields of patient care, public health and health research who assist independent practitioners in providing health services, including nurses (RN and LPN).

Associate Degree Nurse (ADN) - A graduate of an associate degree program of nursing who is eligible for licensure as a registered nurse or is currently licensed in the State in which he/she resides.

Certification - The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications certified by the agency or association.

Certified Medical Assistant (CMA) - The basic certification examination is designed to identify a medical assistant who has the knowledge and skills to perform competently the routine clinical and administrative duties in the office of a primary care physician.

Clinical Tasks - Specific procedures performed to complete needed information leading up to the diagnosis and treatment of patient.

Competent - Having requisite or adequate ability

Credential - As used in this report, the term refers to a document which indicates that an individual has achieved a specified level of competence. Credentialing has three forms: licensure, certification and registration.

Essentials - The minimum requirements for accreditation of an educational program by the AMA Council on Medical Education in collaboration with other appropriate national organizations representing the particular field.

Family Practitioner - General Practitioner - The branch of medicine that is concerned with the diagnosis and treatment of health problems in people in either sex and any age. They often act as the primary health-care providers, referring complicated problems to a specialist.

Health Services - Services available for maintaining, restoring or improving the condition of being sound in body and mind.

Licensed Practical Nurse (LPN) - A licensed practical nurse is an individual who has successfully completed a course of study as prescribed by the Oklahoma Board of Nurses Registration and Nursing Education and the State Department of Vocational and Technical Education, and who, upon completion of the prescribed curriculum, has successfully passed a state board licensing examination.

Licensure - The process by which an agency of government grant permission to persons meeting predetermined qualifications to engage in a given occupations and/or use a particular title; or grants permission to institutions to perform specified functions.

Occupational Competence - Includes technical knowledge and skills, manipulative skills, communication skills, human relations skills, work habits, and the ability to solve problems, to think independently and to make judgments necessary for satisfactory employment in the occupation.

Registered - The process by which qualified individuals are listed on an official roster maintained by a governmental or nongovernmental agency.

Skill - The ability to use one's knowledge effectively and readily in education or performance, a learned power of doing a thing competently.

Task - A task is created whenever human effort, physical or mental, is exerted to accomplish a specific purpose. It is one of the distinct activities that constitutes logical and necessary steps for the performance of work by the worker.

Technician - One who specializes in the technical details of a subject, one who has acquired the ability to perform a complex task or set of tasks. These abilities and skills are usually acquired through formal educational programs of two years or less in length.

Organization of Study

Chapter I introduces the study, presenting the problem, purpose of the study, need for the study, assumptions, limitations and definition of terms. Chapter II includes a review of related literature concerning credentialing of health personnel and the need for credentialing. Chapter III describes the design of research for this study, including the population, the data-gathering instrument, data collection procedures, analysis of data and null hypothesis. The findings of the study are reported in Chapter IV. Chapter V concludes the study with a summary, findings, recommendations and recommendations for further studies.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The Allied Health Personnel have undergone tremendous changes in the past 20 years. Research indicates over 30 new allied health professions have surfaced in this period (23). This factor has provided an increase in health personnel; however, the demand is greater than the supply. In the mid 1960s this demand became a national concern. The first Act of Congress directed specifically to allied health education, The Allied Health Professions Personnel Training Act, was passed in 1966 (13). The purpose of this act was to increase the output of nursing health personnel.

Although a major portion of the need occurred because of an increase in population, part of this deficiency in health personnel is the direct result of increased life expectancy with a rapid change in technology. As medical technology grew, the demand for support personnel to the physician also expanded (16). For purposes of this study, the health personnel will be limited to employees with "nursing" skills; the Registed Nurse, the Licensed Practical Nurse and the Certified Medical Assistant.

This need for additional support personnel is a direct result of the increased usage of nursing services by employers in the following fields: industrial nurse, school nurse, home care service, increase in nursing homes and the military services. Stewart (23) emphasizes that the shortage of personnel has been accelerated by federal programs, including Medicare and Medicaid. The above cited factors have all contributed to the demand for nursing personnel being greater than the supply.

According to the history of medicine, several years ago the hospitals were a place where people went to die, not to recover. Health care is now considered "a right, not a privilege." The public is more health conscious today; therefore, more people are seeking medical care (23).

A study completed by the National Commission on Allied Health (13) in 1980 suggested that the demand for hospitalization will increase an anticipated 50 percent between now and year 2000 in the over 64 age group. This group has a hospital rate three-and-half times greater than the average patient. Patients will also seek increased hospital type services in clinics and the physician's office. This will place an increased burden on nursing personnel.

The Need for Credentialing of Health Personnel

Due to the rise of malpractice claims in the United States, a major concern of the physician when he/she hires

support personnel relates to the credentials of the future employee (11). Can this future employee "legally" perform the required tasks?

There is a misconception by the medical community and the consumer regarding the titles of various allied health personnel. The three most cited credentials accepted in the medical field today are licensure, certification and registration. These titles are interwoven to the extent that it is difficult to study one concept to the exclusion of the other. Literature clearly reveals a picture of dissention among health professionals regarding the meaning of the various credentials.

The problem of credentialing was studied by Pottinger (15) in 1980. This researcher identified five major functions of an occupational credentialing system. These are:

1. define the role, functions, activities and task of the job.
2. determine the characteristics (knowledge, skills, attitudes) workers must have in order to carry out the job.
3. determine ways to access these characteristics.
4. validate their procedures.
5. assure continued competence.

As stated by Pottinger (15, p. 3.1), "credentials are a major gatekeeping mechanism for opportunity to work. They stratify people within society, and they recognize those who have met standards of excellence." Kelly (9) described state boards as "gatekeepers" to the profession to keep out those

"undesirable," limit the number of entrants and cause a favorable economic climate.

Although several methods of credentialing have surfaced in the past, two methods stand out. These are licensure and certification. Several conferences have been held in the United States with prominent health professionals since 1970. These conferences have not produced a concensus of opinion with regard to which credential is the "best" for the health profession.

During the late nineteenth and twentieth centuries state medical societies sponsored the enactment of licensure as a deterrent to the practice of "quackery" in the United States. However, it was not until late 1900s that a significant number of licensing laws related to the health occupations were enacted (19). In Shimberg's (18) study in 1979 of occupational licensing he identified a major concern of medical societies in licensing health personnel. This was to raise the standards of practice and to identify the ethical behavior of these health workers. Originally these statutes were designed to regulate physicians. The licensing laws later incorporated nursing and other allied health personnel.

Prior to 1967 little attention was given to occupational licensure. Literature was scarce and as identified by Shimberg (19) part of the criteria for licensure such as sex, age, education and citizenship were arbitrary; therefore, had little impact on the performance ability of the health worker.

Licensing laws established standards for entry into a

specific field of practice. Therefore, licensure influences the quality of care patients receive.

Studies by Cohen (6), Pottinger (15) and Rafferty (17) indicated that the major criteria for licensure is for "the protection and health of the public." However, are the allied health profession concerned with public safety? The public is not the one who has asked for this protection. The professional organizations seek licensure, obtains licensure and control is given to a State Board. This Board consists of members of the organization who are left to regulate themselves and their peers (23). Research indicates that the profession itself receives the greatest benefit from credentialing of the group. The literature clearly revealed that credentialing of health personnel has improved health care for the patient. However, of equal importance to the profession is the upgrading of the association which also affects the economic status.

The use of titles such as M.D., RN and LPN designate competence in skills identified with these credentials. A study in 1970 sponsored by Health Resources Administration (7) further verified that in addition to confusion with regard to titles, problems also occurred in describing functional performance as well as educational preparation.

The major differences between licensure and certification lies in who issues the credential. Licensure is granted by a governmental agency; certification is granted by nongovernmental or professional organization. Sovie (22) in 1979 stated

that licensure mechanism is one method that States use to protect the health, safety and welfare of the public.

A major drawback of licensure as identified in this research is that each state has their own medical practice acts. These acts define what is included in the practice of medicine within that state and govern the methods and requirements of licensure and the grounds for suspension or revocation of a license.

Milt (10) and Shimberg (19) suggested amending the medical practice acts to authorize broadened delegation of functions as has been done in the statutes of Arizona, Colorado, Kansas and Oklahoma. According to Kelly (9) these statutes have allowed the physician to delegate what they want to whomever they want. American Nurses' Association (4) and Kelly (9) refer to these statutes as "broad delegation" of responsibility. This allows the physician to determine who will perform a specific task.

Rafferty (17) suggests that perhaps the leniency authorized by those broadened statutes would encourage delegation to licensed or unlicensed personnel. Rafferty questions allowing unlicensed personnel to perform medical procedures. However, under the Doctrine of Respondent Superior, that is "Let the Master Answer," the physician is responsible for the acts of all personnel under his/her supervision, licensed or unlicensed. This would discourage delegation of a task to an unqualified individual.

The ruling bodies of the American Medical Association and

the American Hospital Association have criticized licensing for paramedical personnel and called for wider rights of physicians to delegate tasks to medical personnel.

> . . . there is need to avoid the problems of overspecialization and fractionalization of services entailed by occupational licensure systems and the resultant controls on entry into occupations and scope of permissible functions . . .
>
> There seems to be a growing body of opinion that occupational licensure has outlived its usefulness as a method assuring quality health services.
>
> Proliferation in mandatory occupational licensure laws tend to foster a "craft union" approach to health care and may lead to unwarranted increase in cost of services . . .
>
> Current occupational licensure laws tend to inhibit innovations in the education and use of allied health manpower and restrict the avenues available for entry into or upward mobility in a health career . . . (17, p. 128).

Once criteria for licensure is established, it is rigid and difficult to change. Technological advances often alter previous skills. When the scope of practice is locked to a statute, the harder it becomes to make necessary changes.

Papers presented at a nursing institute in 1970 identified the concept of licensure as granting the health profession an illusion of control; however, the presenter was questioning if the nursing profession is keeping up-to-date in nursing skills (14). This thought was further documented by Kelly (9) in 1977. Her study identified licensure as an ineffective method of assuring safe medical care from the health professional. A license is granted which provides unlimited legal right to practice; however, this health employee does not keep his/her skills current.

Another disadvantage of licensure identified by many researchers include rigidity of various statutes which curtail geographic and career mobility. The current method of licensure is felt to often impede effective utilization of health personnel.

A study by Milt (10) in 1971 identified problems with licensure as:

1. laws that were written many years ago are now obsolete,

2. it set rigid educational requirements to deny entry to individuals with suitable experience but without prescribed education,

3. it made no provisions for assuring competence.

Smith (21) questions whether licensure assures competence or does the mechanism place arbitrary and excessive restrictions on entry into a profession. If licensure is the type of credential used, the public must be satisfied that this is the best system.

During the 1960s several new health occupations submitted requests for state licensure. Some of these occupations were licensed, others were not. In 1968 Governor Richard Hughes of New Jersey requested a moratorium on all new occupational licensure in that state pending a thorough review of meaningful criteria to guide decision making in this area (19).

In 1971 the Department of Health, Education and Welfare, American Medical Association and American Nurses' Association called for a two-year moratorium on legislation that would

establish new categories of health personnel with statutorily defined scopes of function (9). The moratorium was suggested to allow time to study alternative methods of credentialing.

Until recent years, licensure alone was considered the essential mechanism for legally recognizing a profession (15). Today, the trend is for certification by the profession itself to be at least as important as licensure in regulating entry into a profession.

According to a pamphlet published by AAMA (1) the primary objectives of certification are:

1. to establish professional standards and goals,

2. to help the physician identify competent medical assistants, and

3. to certify by official means those individuals who successfully complete the examination.

An identified advantage for certification is that this credential is national in scope (16). Thus, the drawback of diverse state standards which prevent geographic mobility would be eliminated.

A study under the auspices of the National Commission for Health Certifying Agencies (12) indicates that certification requirements are ostensibly more demanding and rigorous than educational qualifications as an alternative pathway to meeting licensure requirements.

Milt (10) in 1971 recommended certification and registration for new health occupations instead of licensure. He suggested that standards for certification are generally higher than those set for licensure national standards.

The Health Conference held in 1971 identified certification as a form of licensure (16). The primary purpose of this conference was to identify interrelationship of certification, licensure and accreditation in the allied health professions. Although certification was felt by some of the participants to be the most flexible method of providing credentials to a new paramedical group, several conference participants argued that this method of credentialing would not reduce the fragmentation of health classification.

Coleman, the Vice President of AMA Council in Health Manpower spoke of his concerns over the most effective use of health manpower. In 1971 Coleman (16) stated;

> The standards established by professional groups for certifying the competence of their members are set at a higher rate than those for licensure and are designed to achieve excellence (p. 33).

Although certification is not mandatory according to the government, the employer often requires credentials for employment. Therefore, even though certification and licensure seem to go their separate paths, a considerable amount of overlap is apparent.

Summary

The study by Public Health Services (24) in 1977 clearly indicates that there are problems with the present health manpower licensure and certification system. However, the benefits from these credentials have raised the standards of health care provided in this country.

There is hostility, mistrust and self-interest among health professions. Several studies (2, 6, 15, 18) identified dissention among allied health teams as a serious problem. More team structure with greater interdependence is needed. Rigid restrictions by some health groups have been a determinant of "splinter" groups forming. The National Commission on Allied Health (13) and Pottinger (15) indicated many health personnel are educated in more than one educational role. This employee is described as having "cross-occupational competencies."

A study by Buzek (5) in 1971 suggests the distribution of traditional responsibilities between the physician and health personnel to maximize the output of each participant in the health care team. The three health professions - Registered Nurse, Licensed Practical Nurse and Certified Medical Assistant share competencies in many of the same tasks.

The projected allied health manpower in 1980 indicates the necessity for more allied health personnel, specifically those with nursing skills. Health care cannot exist without personnel to provide patient care. The expanded functions of nurses, and the advancement in health services, are two of the major facts that could cause registered nurses to realize that they alone could not meet the demands for health care and the accelerated needs for more workers to provide that care (3).

Davis (8) testified on behalf of the National League for Nursing before Congress in 1980 that:

> The nation is entering what may be the biggest nursing shortage ever . . . The shortage of nurses in many states has hit crisis proportions among hospitals, nursing homes and some related agencies (p. 7).

Shimberg (19) suggests that elected officials in various states, especially members of state legislatures must accept much of the responsibility for the present chaotic state of occupational licensing. These officials have accepted the legislation, often drafted by the professional organization, and as a result a variety of licenses have been granted with little consistency in requirements, structure, or underlying rationale. After the profession is licensed, a Board is established. This Board consists of members of the profession. A detailed report must be made to the legislature. However, literature reveals these reports have not been evaluated; therefore, is the public being protected?

Literature revealed that licensure, certification and accreditation are credentials respected by society. When the health profession is either licensed or certified the profession issuing the credential is labeling this individual qualified to perform in the identified field. This endorsement identifies competencies in specified areas of the profession. The credentials allows the public to distinguish between the qualified or unqualified personnel.

The need for the proposed study has been clearly identified. The literature researched painted a picture of a nursing shorgage throughout the nation. The usefulness of this research will be dependent upon the applicability of the study as perceived by medical personnel in Northeast Oklahoma.

CHAPTER III

METHODOLOGY

The purpose of this study was to identify how selected medical personnel perceive the different task-performing abilities of licensed versus certified allied health personnel in the State of Oklahoma, specifically Northeast Oklahoma.

This study sought to answer the following questions:

1. Do family practitioners (M.D. and D.O.) perceive differences in the task-performing ability of certification versus licensure as identified by tasks designated to medical personnel holding differing titles?

2. Do hospital administrators perceive differences in the task-performing ability of certification versus licensure as identified by tasks designated to medical personnel holding differing titles?

3. Do directors of nursing services perceive differences in the task-performing ability of certification versus licensure as identified by tasks designated to medical personnel holding differing titles?

4. Does the size of the community affect the perception of the family practitioner with regard to the task performing abilities of licensed versus certified allied health personnel?

5. Does the size of the community affect the perception of the hospital administrator with regard to the task-performing abilities of licensed versus certified allied health personnel?

6. Does the size of the community affect the perception of the directors of nursing services with regard to the task-performing abilities of licensed versus certified allied health personnel?

Population

The primary population for this study was the 156 (100%) medical and osteopathic physicians identified as family practitioners (general practitioners) in eight cities in Northeast Oklahoma. This group was felt to be representative of all physicians. Each physician while undergoing his/her education serve part of his/her internship as a family practitioner.

These physicians were chosen from the cities listed below. The census of each city is listed by the city. The population of each city was obtained from American Automobile Association. This data was obtained from the Chamber of Commerce in each city in 1981.

1. Bartlesville Census - 37,302
2. Broken Arrow Census - 42,454
3. McAlester Census - 17,300
4. Miami Census - 14,200
5. Muskogee Census - 40,000

6. Okmulgee Census - 17,000
7. Sapulpa Census - 18,500
8. Tulsa Census -361,000.

The study also included the hospital administrator and director of nursing services from each hospital located in the above mentioned cities. A total of 13 hospitals were located in these eight cities. The name of the hospital was obtained from the current telephone directory in each of the eight cities.

The name of the family practitioner was determined by use of the current telephone directory in each of the eight cities. All osteopathic physicians as well as medical physicians identified in the yellow pages as either a family or general practitioner were chosen to be included in the survey. The name of the administrator of each hospital was determined by use of the Hospital Directory (2) published by the American Hospital Association. This directory is published each year and identifies each hospital and administrator in the U.S.

A telephone call was made to each hospital in the Tulsa area to obtain the name of the present director of nursing services. The letter was addressed to title designate in those cities where the identification of the nursing director was not known.

Development of the Instrument

The instrument used for this study was a questionnaire developed by the author. Tasks identified in the question-

naire were skills a Certified Medical Assistant, who graduated from a two-year accredited medical assistant program, could perform. The validity of the instrument was tested by a panel of experts (see Appendix A for list). Appropriate suggestions were implemented in the final draft. These experts were chosen for their knowledge in education, nursing and medical assisting. A copy of the final questionnaire is included in Appendix B.

Data Collection Procedures

The questionnaire developed was utilized for each of the three groups chosen; the family practitioner (M.D. and D.O.), the hospital administrator and the director of nursing services of the hospital.

The questionnaire, stamped addressed envelope and a cover letter were mailed January 1, 1983 to 182 individuals. A copy of this letter is included in Appendix C. The questionnaires were coded to identify each participant. Only one family practitioner destroyed the code; however, the population of the city indicated the group with which he should be tabulated.

A second mailing was sent January 18, 1983. A copy of this letter is included in Appendix C. The final date for the results to be included in the study was February 1, 1983. This was felt by the researcher to be sufficient time for response.

Analysis of Data

The instrument utilized was a closed form. The questionnaire items were reviewed and summarized in chart form, utilizing percentages. The Cochran Q statistical analysis was utilized for determining the significance of differences in the medical personnel's perception of varying credentials. According to Siegel (20) the Cochran Q test provides a method for testing whether three or more matched sets of frequencies of proportions differ significantly among themselves. The .01 level of significance was selected as a level which must be obtained before the researcher would reject a null hypothesis.

Null Hypotheses

HO_1: There is no significant differences in the perception of task-performing abilities between the Certified Medical Assistant and licensed nursing personnel by family practitioners in varying sizes of communities.

HO_2: There is no significant differences in the perception of task-performing abilities between the Certified Medical Assistant and licensed nursing personnel by hospital administrators in varying sizes of communities.

HO_3: There is no significant differences in the perception of task-performing abilities between the Certified Medical Assistant and licensed nursing personnel by directors of nursing services in varying sizes of communities.

CHAPTER IV

PRESENTATION OF FINDINGS

The purpose of this study was to identify how selected medical personnel perceive the different task-performing abilities of licensed versus certified allied health personnel. This chapter is organized in the following manner: (1) overall return rate, (2) family practitioners' response, (3) hospital administrators' response, and (4) directors of nursing services' response.

Overall Return Rate

The questionnaire developed was utilized for each of the three groups chosen; the family practitioner (M.D. and D.O.), the hospital administrator and the director of nursing services of the hospital. The return rates by city for the family practitioner are presented in Table I. The total number of respondents was 71 (45.5%) out of a total of 156 participants included in the study. Seventy returns (45%) were useable and utilized for tabulating results.

The return rate from cities with population of 14,000 to 18,000 was a total of 50 percent; the return rate from cities with population of 35,000 to 42,000 was 50 percent; however, the return rate from Tulsa with a population of 351,000 plus

was only 40 percent. The largest percentage of returns was from Bartlesville; the lowest percentage of returns was from Muskogee.

TABLE I

RESPONSE RATE FOR FAMILY PRACTITIONERS BY CITY

City	Number Distributed	Number Responding	Percent Responding
Bartlesville	10	8	80%
Broken Arrow	17	8	47%
McAlester	10	4	40%
Miami	11	4	36%
Muskogee	15	5	33%
Okmulgee	6	4	67%
Sapulpa	17	10	59%
Tulsa	70	27	39%
Total	156	70	45%

The return by city for hospital administrators is presented in Table II. The total number of respondents was five (38%) out of a total of 13 included in the study. One respondent returned the questionnaire; however, he stated the director of nursing services had completed the questionnaire

and left all statements blank. Four (31%) were useable and utilized when tabulating results. The largest number of returns (two) were from Tulsa with one each from Miami and Muskogee.

TABLE II

RESPONSE RATE FOR HOSPITAL ADMINISTRATORS BY CITY

City	Number Distributed	Number Responding	Percent Responding
Bartlesville	1	0	0%
Broken Arrow	1	0	0%
McAlester	1	0	0%
Miami	1	1	100%
Muskogee	1	1	100%
Okmulgee	1	0	0%
Sapulpa	1	0	0%
Tulsa	6	2	33%
Total	13	4	31%

The return rate by city for directors of nursing services is presented in Table III. The total number of respondents were nine (69%) out of a total of 13 included in the study. Eight (62%) returns were useable and utilized when tabulating results. The largest number of returns (four) was from Tulsa

with one each from Broken Arrow, McAlester, Okmulgee and Sapulpa.

TABLE III

RESPONSE RATE FOR DIRECTORS OF NURSING SERVICES BY CITY

City	Number Distributed	Number Responding	Percent Responding
Bartlesville	1	0	0%
Broken Arrow	1	1	100%
McAlester	1	1	100%
Miami	1	0	0%
Muskogee	1	0	0%
Okmulgee	1	1	100%
Sapulpa	1	1	100%
Tulsa	6	4	66%
Total	13	8	62%

Family Practitioners' Response

The questionnaire identified 44 tasks which a Certified Medical Assistant, who graduated from a two-year accredited medical assistant program, could perform. These tasks were divided into three divisions: patient instruction, clinical

assisting and diagnostic procedures/equipment. This division was to provide easier readability for the respondent.

The responses of the family practitioner (M.D. and D.O.) from cities with populations of 14,000 to 18,000 are presented in Table IV. These cities include McAlester, Miami, Okmulgee, and Sapulpa. The total number of respondents was 22 (50%) out of a total of 44 included in the study.

Overall, there was not a marked difference in the perception of the family practitioner in the delegation of tasks to title designates. The greatest percentage range in the section on patient instruction was in tasks 4, 6 and 8. These relate to instructing patient in how to change dressing, verify and repeat physician's instructions for a confused patient and discuss and instruct diet/nutrition therapy with a patient. The lowest percentage range of responses in the section under clinical assisting was in assisting the physician in minor surgery (task 5), removing sutures (task 7), administration of medication (tasks 8 and 9), and preparing catheterization tray and assisting in catheterization of patient (task 10). In the section under diagnostic procedures/equipment, the greatest percentage range is task five, which is obtaining an EKG tracing and monitoring for abnormal tracings. All three title designates received low ratings regarding their perceived ability to perform tasks 23 through 26. These tasks are normally performed by a medical laboratory technician in the hospital setting.

TABLE IV

RESPONSE RATE FOR FAMILY PRACTITIONERS' PERCEPTION OF TASK-PERFORMING ABILITIES BY TYPE OF CREDENTIALS IN CITIES OF 14,000 TO 18,000*

Task	Credential CMA N	%	RN N	%	LPN N	%
Patient Instruction						
01 Instruct patient in examination procedure	(18)	82%	(21)	95%	(21)	95%
02 Instruct patient in preparation for lab tests ordered by physician	(18)	82%	(21)	95%	(22)	100%
03 Instruct patient how to prepare for x-ray procedure	(20)	91%	(22)	100%	(21)	95%
04 Verify/repeat physician's instructions for confused patient	(14)	64%	(22)	100%	(19)	86%
05 Instruct patient in how to care for incision/ wound	(17)	77%	(22)	100%	(21)	95%
06 Instruct patient in how to change dressing	(18)	82%	(21)	95%	(22)	100%
07 Instruct patient as how to wrap elastic bandage	(17)	77%	(21)	95%	(22)	100%
08 Discuss and instruct diet/ nutrition therapy	(11)	50%	(20)	91%	(18)	82%
Clinical Assisting						
01 Prepare/drape patient for examination	(21)	95%	(22)	100%	(21)	95%
02 Explain examination procedure to patient	(17)	77%	(22)	100%	(21)	95%
03 Position patient for examination	(20)	91%	(22)	100%	(21)	95%
04 Prepare treatment room/tray for minor surgery	(21)	95%	(21)	95%	(21)	95%
05 Assist physician in minor surgery	(16)	73%	(21)	95%	(21)	95%

TABLE IV (Continued)

	Task	Credential CMA N	%	RN N	%	LPN N	%
Clinical Assisting Continued							
06	Apply/remove surgical bandaging as directed by physician	(18)	82%	(22)	100%	(20)	91%
07	Remove sutures, as directed by physician	(15)	68%	(21)	95%	(20)	91%
08	Administer inoculations, as directed by physician	(14)	64%	(21)	95%	(21)	95%
09	Administer medication, as directed by physician	(14)	64%	(21)	95%	(21)	95%
10	Prepare catheterization tray and assist in catheterization of patient	(16)	73%	(21)	95%	(19)	86%
Diagnostic Procedures/Equipment							
01	Take/record patient's weight and height	(21)	95%	(21)	95%	(21)	95%
02	Take/record patient's blood pressure, pulse rate, respiration rate	(20)	91%	(21)	95%	(22)	100%
03	Prepare/test EKG machine for proper,safe operation	(19)	86%	(22)	100%	(21)	95%
04	Prepare/instruct/assist patient for EKG exam	(20)	91%	(21)	95%	(22)	100%
05	Obtain EKG tracing;monitor for abnormal tracing	(12)	54%	(21)	95%	(19)	86%
06	Label/mount tracings	(21)	95%	(21)	95%	(22)	100%
07	Position/prepare patient for x-ray	(19)	86%	(19)	86%	(20)	91%
08	Take routine x-rays, per physician's orders	(13)	59%	(17)	77%	(13)	59%
09	Develop x-ray film	(16)	73%	*16)	73%	(15)	68%
10	Instruct patient in proper collection of specimen	(21)	95%	(21)	95%	(21)	95%

TABLE IV (Continued)

	Task	Credential CMA N	CMA %	RN N	RN %	LPN N	LPN %
Diagnostic Procedures Continued							
11	Collect urine/fecal specimen from patient	(21)	95%	(21)	95%	(22)	100%
12	Collect nose,throat specimen	(18)	82%	(20)	91%	(21)	95%
13	Prepare specimen for transport to laboratory	(19)	86%	(21)	95%	(22)	100%
14	Perform macroscopic examination of urine	(16)	72%	(19)	86%	(18)	82%
15	Centrifuge urine specimen sample	(20)	91%	(20)	91%	(21)	95%
16	Perform microscopic exam of urine	(14)	64%	(15)	68%	(15)	68%
17	Perform urinalysis dip stick test, i.e., sugar, albumin, acetone	(21)	95%	(19)	86%	(21)	95%
18	Perform specific gravity test on urine	(20)	91%	(17)	77%	(19)	86%
19	Determine/separate by method of sterilization items to be sterilized	(20)	91%	(18)	82%	(20)	91%
20	Wrap/sterilize instruments, equipment, material	(21)	95%	(18)	82%	(20)	91%
21	Obtain blood specimen from capillary, finger	(20)	91%	(16)	72%	(18)	82%
22	Obtain venous blood sample	(19)	86%	(18)	82%	(19)	86%
23	Perform diff. cell count	(10)	45%	(11)	50%	(08)	36%
24	Perform white cell count	(09)	41%	(11)	50%	(08)	36%
25	Perform red cell count	(09)	91%	(10)	45%	(11)	50%
26	Perform hemoglobin hematocrit test	(11)	50%	(11)	50%	(11)	50%

*Number responding - 22

The responses of the family practitioner (M.D. and D.O.) from cities with population of 35,000 to 42,000 are presented in Table V. These cities include Bartlesville, Broken Arrow, and Muskogee. The total number of respondents was 21 (50%) out of a total of 42 included in the study.

The family practitioner from the cities with population of 35,000 to 42,000 gave the Certified Medical Assistant a higher rating on tasks one and two in the section concerning patient instruction. These tasks involved preparing patients for examination and preparation for lab tests. Again, the greatest range of response in this section was task eight. This task involved discussing and instructing diet/nutrition therapy. Several doctors wrote additional comments by this skill indicating that he/she felt only a dietitian or a physician should perform this specific procedure.

The highest percentage rating received by the Certified Medical Assistant in the section clinical assisting included preparing, draping (task 1), positioning the patient for examination (task 3) as well as explaining the procedure to the patient (task 2). The widest percentage range in the perception of task delegation by family practitioners in this section was in the administration of medication (tasks 8 and 9), as well as the preparation of the catheterization tray and assisting the physician in the examination (task 10). The RN and LPN were assigned the greatest responsibility in the performance of these tasks.

The last section of the questionnaire which covered

TABLE V

RESPONSE RATE FOR FAMILY PRACTITIONERS' PERCEPTION OF TASK-PERFORMING ABILITIES BY TYPE OF CREDENTIAL IN CITIES OF 35,000 TO 42,000*

Task	Credential CMA N	CMA %	RN N	RN %	LPN N	LPN %
Patient Instruction						
01 Instruct patient in examination preparation	(19)	90%	(16)	76%	(16)	76%
02 Instruct patient in preparation for lab tests ordered by physician	(18)	86%	(17)	81%	(16)	76%
03 Instruct patient how to prepare for x-ray procedures	(14)	67%	(15)	71%	(14)	67%
04 Verify/repeat physician's instructions for confused patient	(12)	57%	(16)	76%	(13)	63%
05 Instruct patient in care of incision/wound	(12)	57%	(16)	76%	(13)	62%
06 Instruct patient in how to change dressing	(12)	57%	(16)	76%	(17)	81%
07 Instruct patient as how to wrap elastic bandage	(14)	67%	(16)	76%	(16)	76%
08 Discuss and instruct diet/nutrition therapy	(09)	38%	(16)	76%	(15)	71%
Clinical Assisting						
01 Prepare/drape patient for examination	(19)	90%	(16)	76%	(16)	76%
02 Explain examination procedure to patient	(17)	81%	(15)	71%	(14)	67%
03 Position patient for examination	(17)	81%	(16)	76%	(16)	76%
04 Prepare treatment room/tray for minor surgery	(15)	71%	(16)	76%	(15)	71%
05 Assist physician in minor surgery	(15)	71%	(17)	81%	(16)	76%

TABLE V (Continued)

Task	Credential CMA N	CMA %	RN N	RN %	LPN N	LPN %
Clinical Assisting Continued						
06 Apply/remove surgical bandaging as directed by physician	(16)	76%	(16)	76%	(16)	76%
07 Remove sutures, as directed by physician	(15)	71%	(15)	71%	(15)	71%
08 Administer inoculations, as directed by physician	(13)	62%	(17)	81%	(17)	81%
09 Administer medication, as directed by physician	(13)	62%	(17)	81%	(16)	76%
10 Prepare catheterization tray and assist in catheterization of patient	(11)	52%	(17)	81%	(16)	76%
Diagnostic Procedures/Equipment						
01 Take/record patient's weight and height	(20)	95%	(16)	76%	(17)	81%
02 Take/record patient's blood pressure, pulse rate, respiration rate	(16)	76%	(16)	76%	(17)	81%
03 Prepare/test EKG machine for proper,safe operation	(14)	67%	(14)	67%	(15)	71%
04 Prepare/instruct/assist patient for EKG exam	(15)	71%	(14)	67%	(15)	71%
05 Obtain EKG tracing/monitor for abnormal tracing	(11)	52%	(13)	62%	(13)	62%
06 Lebel/mount tracings	(15)	71%	(14)	67%	(15)	71%
07 Position/prepare patient for x-ray	(15)	71%	(13)	62%	(12)	57%
08 Take routine x-rays, per physician's orders	(13)	62%	(11)	52%	(11)	52%
09 Develop x-ray film	(15)	71%	(12)	57%	(12)	57%
10 Instruct patient in proper collection of specimen	(17)	81%	(17)	81%	(16)	76%

TABLE V (Continued)

	Task	Credential CMA N	%	RN N	%	LPN N	%
Diagnostic Procedures Continued							
11	Collect urine/fecal specimen from patient	(17)	81%	(17)	81%	(17)	81%
12	Collect nose,throat specimen	(14)	67%	(16)	76%	(16)	76%
13	Prepare specimens for transport to laboratory	(16)	76%	(17)	81%	(17)	81%
14	Perform macroscopic examination of urine	(14)	67%	(14)	67%	(14)	67%
15	Centrifuge urine specimen sample	(15)	71%	(14)	67%	(14)	67%
16	Perform microscopic exam of urine	(10)	48%	(11)	52%	(09)	43%
17	Perform urinalysis dip stick test, i.e., sugar, albumin, acetone	(20)	95%	(17)	81%	(17)	81%
18	Perform specific gravity test on urine	(18)	86%	(15)	71%	(17)	81%
19	Determine/separate by method of sterilization items to be sterilized	(16)	76%	(17)	81%	(16)	76%
20	Wrap/sterilize instruments, equipment, material	(16)	76%	(17)	81%	(17)	81%
21	Obtain blood specimen from capillary, finger	(15)	71%	(14)	67%	(14)	67%
22	Obtain venous blood sample	(14)	67%	(14)	67%	(13)	62%
23	Perform diff. cell count	(10)	48%	(11)	52%	(09)	43%
24	Perform white cell count	(10)	48%	(10)	48%	(09)	43%
25	Perform red cell count	(10)	48%	(10)	48%	(08)	38%
26	Perform hemoglobin/ hematocrit test	(12)	57%	(13)	62%	(13)	62%

*Number responding - 21

diagnostic procedures/equipment did not identify a wide range in the perception of task delegation by the family practitioners with regard to these titles. The exceptions in this area was task 5 which relates to obtaining an EKG tracing and monitoring for abnormal tracings. All three title designates received low ratings in tasks 23 through 26. These are normally performed by a medical laboratory technician in the hospital setting.

The responses of the family practitioners (M.D. and D.O.) from the city of Tulsa with population of 351,000+ are presented in Table VI. The total number of respondents were 27 (39%) out of a total of 70 included in the study.

The responses of the family practitioners from Tulsa did not identify a perceived difference in the task performing abilities of these title designates.

A higher rating was given to the Certified Medical Assistant in the section for patient instruction; these include tasks 1 and 2. These relate to instructing the patient in examination preparation and lab test preparation. Again, the lowest mark received by the CMA in this area was task 8. This relates to discussing and instructing patient in diet/nutrition therapy.

The family practitioners from this population did not identify a perceived difference in the task-performing abilities of either the licensed or certified allied health personnel in the section clinical assisting. The three title designates received extremely close ratings.

TABLE VI

RESPONSE RATE FOR FAMILY PRACTITIONERS' PERCEPTION OF TASK-PERFORMING ABILITIES BY TYPE OF CREDENTIALS IN CITY OF 350,000+, TULSA*

Task	Credential CMA N	CMA %	RN N	RN %	LPN N	LPN %
Patient Instruction						
01 Instruct patient in examination procedure	(24)	89%	(20)	74%	(23)	85%
02 Instruct patient in preparation for lab tests ordered by physician	(24)	89%	(21)	78%	(22)	81%
03 Instruct patient how to prepare for x-ray procedure	(20)	74%	(21)	78%	(24)	89%
04 Verify/repeat physician's instructions for confused patient	(21)	78%	(22)	81%	(21)	78%
05 Instruct patient in care of incision/wound	(18)	67%	(21)	78%	(22)	81%
06 Instruct patient in how to change dressing	(18)	67%	(21)	78%	(21)	78%
07 Instruct patient as how to wrap elastic bandage	(21)	78%	(21)	78%	(22)	81%
08 Discuss and instruct diet/nutrition therapy	(16)	59%	(19)	70%	(18)	67%
Clinical Assisting						
01 Prepare/drape patient for examination	(24)	89%	(22)	81%	(24)	89%
02 Explain examination procedure to patient	(23)	85%	(23)	85%	(24)	89%
03 Position patient for examination	(24)	89%	(22)	81%	(24)	89%
04 Prepare treatment room/tray for minor surgery	(23)	85%	(22)	81%	(24)	89%
05 Assist physician in minor surgery	(21)	78%	(23)	85%	(24)	89%

TABLE VI (Continued)

Task	Credential CMA N	%	RN N	%	LPN N	%
Clinical Assisting Continued						
06 Apply/remove surgical bandaging as directed by physician	(21)	78%	(21)	78%	(24)	89%
07 Remove sutures, as directed by physician	(22)	81%	(22)	81%	(22)	81%
08 Administer inoculations, as directed by physician	(20)	74%	(23)	85%	(24)	89%
09 Administer medication, as directed by physician	(20)	74%	(22)	85%	(23)	85%
10 Prepare catheterization tray and assist in catheterization of patient	(21)	78%	(23)	85%	(23)	85%
Diagnostic Procedures/Equipment						
01 Take/record patient's weight and height	(24)	89%	(21)	78%	(24)	89%
02 Take/record patient's blood pressure, pulse rate, respiration rate	(23)	85%	(22)	81%	(24)	89%
03 Prepare/test EKG machine for proper,safe operation	(23)	85%	(20)	74%	(22)	81%
04 Prepare/instruct/assist patient for EKG exam	(22)	81%	(19)	70%	(21)	78%
05 Obtain EKG tracing;monitor for abnormal tracing	(16)	59%	(18)	67%	(15)	56%
06 Label/mount tracings	(21)	78%	(18)	67%	(18)	67%
07 Position/prepare patient for x-ray	(20)	75%	(20)	74%	(21)	78%
08 Take routine x-rays, per physician's orders	(19)	70%	(18)	67%	(18)	67%
09 Develop x-ray film	(23)	85%	(21)	78%	(19)	70%
10 Instruct patient in proper collection of specimen	(74)	89%	(23)	85%	(24)	89%

TABLE VI (Continued)

	Task	Credential CMA N	%	RN N	%	LPN N	%
Diagnostic Procedures Continued							
11	Collect urine/fecal specimen from patient	(24)	89%	(23)	81%	(24)	89%
12	Collect nose,throat specimen	(18)	67%	(21)	78%	(22)	81%
13	Prepare specimens for transport to laboratory	(23)	85%	(21)	78%	(23)	85%
14	Perform macroscopic examination of urine	(20)	74%	(20)	74%	(21)	78%
15	Centrifuge urine specimen sample	(21)	78%	(19)	70%	(22)	81%
16	Perform microscopic exam of urine	(18)	67%	(17)	63%	(14)	52%
17	Perform urinalysis dip stick test, i.e., sugar, albumin, acetone	(23)	85%	(21)	78%	(23)	85%
18	Perform specific gravity test on urine	(23)	85%	(21)	78%	(23)	85%
19	Determine/separate by method of sterilization items to be sterilized	(22)	81%	(22)	81%	(22)	81%
20	Wrap/sterilize instruments, equipment, material	(22)	81%	*22)	81%	(23)	85%
21	Obtain blood specimen from finger, capillary	(20)	74%	(21)	78%	(22)	81%
22	Obtian venous blood sample	(18)	67%	(21)	78%	(21)	78%
23	Perform diff. cell count	(12)	44%	(18)	67%	(12)	44%
24	Perform white cell count	(11)	41%	(17)	63%	(12)	44%
25	Perform red cell count	(11)	41%	*17(	63%	(12)	44%
26	Perform hemoglobin/ hematocrit test	(16)	59%	(18)	67%	(19)	70%

*Number responding - 27

In the last section, diagnostic procedures/equipment, the greatest range of percentages was found in tasks 23 through 26. However, in these tasks the Registered Nurse received a much higher rating than both the Certified Medical Assistant and the Licensed Practical Nurse. The physician is more familiar with the laboratory setting of the hospital and this possibly accounts for his/her perception of task-performing abilities by these title designates.

The responses of the family practitioner (M.D. and D.O.) from the total population are presented in Table VII. The total number of respondents were 70 out of a total of 156 included in the study.

Overall, there was not a great difference in the perception of the family practitioner, total population, in the delegation of tasks to either a licensed or certified allied health personnel.

The Cochran Q statistical analysis was utilized to determine the signifiance of differences of the responses of the family practitioners from differing populations. The .01 level of significance was selected as a level which must be obtained before the researcher would reject a null hypotheses.

HO_1: There is no significant differences in the perception of task-performing abilities between the Certified Medical Assistant and licensed nursing personnel by family practitioners in varying sizes of communities.

The Cochran Q calculated value is listed in a column in Table VII with X_2 value given at the end of the table. X_2

table value 9.210 with 2 degrees of freedom. Significant $p < .01$.

The tasks (1.8%) which identified a significant difference includes task 5 in the section on patient instruction. This task was instructing the patient in how to change a dressing. The most significant perceived difference in this section was task 8. This relates to discussing and instructing diet/nutrition therapy to a patient. Several physician's identified this procedure to be the responsibility of either a dietitian or a physician.

The greatest perceived differences by the family practitioner in the section under clinical assisting was tasks 8, 9, and 10. Tasks 8 and 9 relate to the administration of medication; task 10 is preparing catheterization tray and assisting in the catheterization of the patient.

The last section, diagnostic procedures/equipment, identified tasks 5, 24, 25 as being perceived significantly different in the delegation of tasks by these practitioners. Task 5 is obtaining an EKG tracing and monitoring for abnormal results. Tasks 24 and 25 include hematology procedures, white blood cell count and red blood cell count. Again, these tasks are normally performed in the hospital setting where specialization is emphasized.

TABLE VII

RESPONSE RATE FOR FAMILY PRACTITIONERS' PERCEPTION OF TASK-PERFORMING ABILITIES BY TYPE OF CREDENTIAL

Task	Credential CMA N	%	RN N	%	LPN N	%	Cochran Q
Patient Instruction							
01 Instruct patient in examination preparation	(61)	87%	(57)	81%	(60)	86%	2.375
02 Instruct patient in preparation for lab tests ordered by physician	(60)	86%	(59)	84%	(60)	86%	0.444
03 Instruct patient how to prepare for x-ray procedures	(54)	77%	(58)	83%	(59)	84%	3.111
04 Verify/repeat physician's instructions for confused patient	(47)	67%	(60)	85%	(53)	76%	9.071
05 Instruct patient in care of incision/wound	(47)	67%	(58)	84%	(56)	80%	7.357
06 Instruct patient in how to change dressing	(48)	69%	(58)	83%	(63)	90%	13.461*
07 Instruct patient as how to wrap elastic bandage	(52)	74%	(58)	83%	(60)	86%	4.900
08 Discuss and instruct diet/nutritiontherapy	(35)	50%	(55)	79%	(51)	73%	13.555*
Clinical Assisting							
01 Prepare/drape patient for examination	(64)	91%	(60)	86%	(61)	87%	1.857
02 Explain examination procedure to patient	(57)	81%	(60)	86%	(59)	84%	1.368

TABLE VII (Continued)

Task	Credential CMA N	CMA %	RN N	RN %	LPN N	LPN %	Cochran Q
Clinical Assisting Continued							
03 Position patient for examination	(61)	87%	(60)	86%	(61)	87%	0.133
04 Prepare treatment room/tray for minor surgery	(59)	84%	(59)	84%	(60)	86%	0.736
05 Assist physician in minor surgery	(52)	74%	(61)	87%	(61)	87%	2.100
06 Apply/remove surgical bandaging as directed by physician	(55)	79%	(59)	84%	(60)	86%	2.952
07 Remove sutures, as directed by physician	(52)	74%	(58)	83%	(57)	81%	2.434
08 Administer inoculations, as directed by physician	(47)	67%	(61)	87%	(62)	89%	19.000*
09 Administer medication, as directed by physician	(47)	67%	(60)	86%	(60)	86%	16.692*
10 Prepare catheterization tray and assist in catheterization of patient	(48)	69%	(61)	86%	(58)	83%	13.760*
Diagnostic Procedures/Equipment							
01 Take/record patient's weight and height	(65)	93%	(59)	84%	(62)	89%	2.923
02 Take/record patient's blood pressure, pulse rate, respiration rate	(59)	84%	(59)	84%	(63)	90%	1.733
03 Prepare/test EKG machine for proper, safe operation	(56)	80%	(56)	80%	(58)	83%	1.000

TABLE VII (Continued)

	Task	Credential CMA N	CMA %	RN N	RN %	LPN N	LPN %	Cochran Q
04	Prepare/instruct/assist patient for EKG exam	(57)	81%	(54)	77%	(58)	83%	1.714
05	Obtain EKG tracing; monitor for abnormal tracing	(39)	56%	(52)	74%	(47)	67%	10.207*
06	Label/mount tracings	(57)	81%	(53)	76%	(55)	79%	1.166
07	Position/prepare patient for x-ray	(54)	77%	(52)	74%	(53)	76%	1.166
08	Take routine x-rays, per physician's order	(45)	64%	(46)	66%	(42)	60%	1.529
09	Develop x-ray film	(54)	77%	(49)	70%	(46)	66%	5.166
10	Instruct patient in proper collection of specimen	(62)	89%	(61)	87%	(61)	87%	0.500
11	Collect urine/fecal specimen from patient	(62)	89%	(60)	86%	(63)	90%	1.166
12	Collect nose, throat specimen	(50)	71%	(57)	81%	(59)	84%	6.777
13	Prepare specimens for transport/laboratory	(58)	83%	(59)	84%	(62)	89%	0.615
14	Perform macroscopic examination of urine	(50)	71%	(53)	76%	(53)	76%	2.818
15	Centrifuge urine specimen sample	(56)	80%	(54)	77%	(57)	81%	1.384
16	Perform microscopic exam of urine	(42)	60%	(43)	61%	(38)	54%	3.629
17	Perform urinalysis dip stick test, i.e., sugar, albumin, acetone	(64)	91%	(57)	81%	(61)	87%	1.384

TABLE VIII (Continued)

	Task	Credential CMA N	%	RN N	%	LPN N	%	Cochran Q
Diagnostic Procedures Continued								
18	Perform specific gravity test on urine	(61)	87%	(53)	76%	(59)	84%	3.230
19	Determine/separate by method of sterilization items to be sterilized	(58)	83%	(57)	81%	(58)	83%	0.125
20	Wrap/sterilize instruments, equipment, material	(59)	84%	(57)	81%	(60)	86%	0.400
21	Obtain blood specimen from capillary, finger	(55)	79%	(51)	73%	(54)	77%	0.533
22	Obtain venous blood sample	(51)	73%	(53)	76%	(53)	76%	1.300
23	Perform differential cell count	(32)	46%	(40)	57%	(29)	41%	9.090
24	Perform white blood cell count	(30)	43%	(38)	54%	(28)	40%	11.100*
25	Perform red blood cell count	(30)	43%	(37)	52%	(29)	41%	11.100*
26	Perform hemoglobin/hematocrit test	(39)	56%	(32)	46%	(43)	61%	4.105

**Number responding - 70

X_2 .01 df 2, is 9.210

*Significant $p < .01$

Hospital Administrators' Response

The response of the hospital administrators are presented in Table VIII. The total number of respondents was four. out of a total of 13 in the study. Insufficient sample size prevented data from being presented in tables for each population. The null hypothesis was not tested as an inadequate responses were received.

The hospital administrator's perceived the Registered Nurse as having the greatest responsibility in each of the 44 tasks included in the questionnaire. The lowest rating for the RN was in tasks which involved laboratory techniques. This is probably due to the hospital specialization most recognized by this group of respondents. The title designate Licensed Practical Nurse and Certified Medical Assistant were given similar ratings by the administrators. The lowest responses for the CMA were in the tasks 7, 8 and 9 in the section clinical assisting. No marks were given in these tasks for the LPN or CMA. Of interest, under the third section, the CMA received the only marks for tasks 23 through 26 with the RN and LPN receiving none.

Directors of Nursing Services' Response

The responses of the directors of nursing services are presented in Table IX. The total number of respondents were eight out of a total of 13 in the study. Insufficient response prevented data from being presented in tables for each population. The null hypothesis was not tested as inadequate responses were received.

TABLE VIII

RESPONSE RATE FOR HOSPITAL ADMINISTRATORS' PERCEPTION OF TASK-PERFORMING ABILITIES BY TYPE OF CREDENTIAL*

Task	Credential CMA N	%	RN N	%	LPN N	%
Patient Instruction						
01 Instruct patient in examination preparation	(2)	50%	(3)	75%	(2)	50%
02 Instruct patient in preparation for lab tests ordered by physician	(2)	50%	(3)	75%	(2)	50%
03 Instruct patient how to prepare for x-ray procedures	(3)	75%	(3)	75%	(2)	50%
04 Verify/repeat physician's instructions for confused patient	(2)	50%	(3)	75%	(1)	25%
05 Instruct patient in care of incision/wound	(1)	25%	(3)	75%	(1)	25%
06 Instruct patient as how to change dressing	(2)	50%	(3)	75%	(1)	25%
07 Instruct patient as how to wrap elastic bandage	(3)	75%	(3)	75%	(1)	25%
08 Discuss and instruct diet/nutrition therapy	(1)	25%	(2)	50%	(1)	25%
Clinical Assisting						
01 Prepare/drape patient for examination	(3)	75%	(3)	75%	(2)	50%
02 Explain examination procedure to patient	(1)	25%	(3)	75%	(1)	25%
03 Position patient for examination	(2)	50%	(3)	75%	(2)	50%
04 Prepare treatment room/tray for minor surgery	(2)	50%	(3)	75%	(2)	50%
05 Assist physician in minor surgery	(2)	50%	(3)	75%	(2)	50%

TABLE VIII (Continued)

	Task	Credential CMA N	%	RN N	%	LPN N	%
Clinical Assisting Continued							
06	Apply/remove surgical bandaging as directed by physician	(1)	25%	(3)	75%	(2)	50%
07	Remove sutures, as directed by physician	(0)	0%	(4)	100%	(1)	25%
08	Administer inoculations, as directed by physician	(0)	0%	(4)	100%	(3)	75%
09	Administer medication, as directed by physician	(0)	0%	(4)	100%	(3)	75%
10	Prepare catheterization tray and assist in catheterization of patient	(2)	50%	(4)	100%	(3)	75%
Diagnostic Procedures/Equipment							
01	Take/record patient's weight and height	(3)	75%	(3)	75%	(2)	50%
02	Take/record patient's blood pressure, pulse rate, respiration rate	(3)	75%	(2)	50%	(2)	50%
03	Prepare/test EKG machine for proper, safe operation	(3)	75%	(2)	50%	(2)	50%
04	Prepare/instruct/assist patient for EKG exam	(3)	75%	(3)	75%	(2)	50%
05	Obtain EKG tracing; monitor for abnormal tracing	(2)	50%	(2)	50%	(1)	25%
06	Label/mount tracings	(3)	75%	(2)	50%	(2)	50%
07	Position/prepare patient for x-ray	(2)	50%	(1)	25%	(1)	25%
08	Take routine x-rays, per physician's orders	(2)	50%	(1)	25%	(1)	25%
09	Develop x-ray film	(2)	50%	(1)	25%	(1)	25%
10	Instruct patient in proper collection of specimen	(3)	75%	(3)	75%	(2)	50%

TABLE VIII (Continued)

	Task	Credential CMA N	CMA %	RN N	RN %	LPN N	LPN %
Diagnostic Procedures Continued							
11	Collect urine/fecal specimen from patient	(3)	75%	(3)	75%	(2)	50%
12	Collect nose,throat specimen	(1)	25%	(3)	75%	(2)	50%
13	Prepare specimens for transport to laboratory	(3)	75%	(3)	75%	(2)	50%
14	Perform macroscopic examination of urine	(2)	50%	(1)	25%	(1)	25%
15	Centrifuge urine specimen sample	(3)	75%	(2)	50%	(2)	50%
16	Perform microscopic exam of urine	(2)	50%	(1)	25%	(1)	25%
17	Perform urinalysis dip stick test, i.e., sugar, albumin, acetone	(2)	50%	(2)	50%	(2)	50%
18	Perform specific gravity test on urine	(2)	50%	(2)	50%	(2)	50%
19	Determine/separate by method of sterilization items to be sterilized	(1)	25%	(2)	50%	(1)	25%
20	Wrap/sterilize instruments, equipment, material	(2)	50%	(2)	50%	(1)	25%
21	Obtain blood specimen from capillary, finger	(2)	50%	(3)	75%	(2)	50%
22	Obtain venous blood sample	(2)	50%	(3)	75%	(1)	25%
23	Perform diff cell count	(1)	25%	(0)	0%	(0)	0%
24	Perform white cell count	(1)	25%	(0)	0%	(0)	0%
25	Perform red cell count	(1)	25%	(0)	0%	(0)	0%
26	Perform hemoglobin/hct test	(1)	25%	(0)	0%	(0)	0%

*Number responding - 4

The perception of the directors of nursing services regarding the task-performing abilities of licensed versus certified allied health personnel indicated the greatest range variation in the three groups surveyed. In the first section, patient instruction, the Certified Medical Assistant received zero percent in tasks 1, 6 and 8; however, the Registered Nurse was perceived as performing 100 percent of the tasks 4, 5, 6, 7, and 8.

The Certified Medical Assistant received 13 percent of task delegation in the section on medical assisting, while the Registered Nurse was perceived to be capable of performing 100 percent of the tasks 1 through 10. The ratings of the Licensed Practical Nurse were similar to the RN ratings. In the section, diagnostic equipment/procedures, the Certified Medical Assistant received a 13 percent response on each task numbered 23 through 26. These tasks dealt with hematology reports. The Registered Nurse and Licensed Practical Nurse were perceived as not capable of performing these tasks, they each received zero percent in task delegation. However, these skills are normally performed in the laboratory setting of the hospital and they are expected to be performed by these allied health personnel.

TABLE IX

RESPONSE RATE FOR DIRECTORS OF NURSING SERVICES' PERCEPTION OF TASK-PERFORMING ABILITIES BY TYPE OF CREDENTIALS*

Task	Credential CMA N	CMA %	RN N	RN %	LPN N	LPN %
TASK						
Patient Instruction						
01 Instruct patient in examination preparation	(0)	0%	(7)	88%	(6)	75%
02 Instruct patient in preparation for lab tests ordered by physician	(1)	13%	(7)	88%	(6)	75%
03 Instruct patient how to prepare for x-ray procedures	(1)	13%	(7)	88%	(6)	75%
04 Verify/repeat physician's instructions for confused patient	(2)	25%	(8)	100%	(7)	88%
05 Instruct patient in care of incision/wound	(1)	13%	(8)	100%	(5)	63%
06 Instruct patient in how to change dressing	(0)	0%	(8)	100%	(5)	63%
07 Instruct patient as how to wrap elastic bandage	(3)	38%	(8)	100%	(6)	75%
08 Discuss and instruct diet/ nutrition therapy	(0)	0%	(8)	100%	(4)	50%
Clinical Assisting						
01 Prepare/drape patient for examination	(5)	63%	(7)	88%	(6)	75%
02 Explain examination procedure to patient	(3)	38%	(8)	100%	(5)	63%
03 Position patient for examination	(5)	63%	(8)	100%	(6)	75%
04 Prepare treatment room/ tray for minor surgery	(3)	38%	(8)	100%	(7)	88%
05 Assist physician in minor surgery	(1)	13%	(8)	100%	(7)	88%

TABLE IX (Continued)

	Task	Credential CMA N	%	RN N	%	LPN N	%
Clinical Assisting Continued							
06	Apply/remove surgical bandaging as directed by physician	(2)	25%	(8)	100%	(7)	88%
07	Remove sutures, as directed by physician	(2)	25%	(8)	100%	(5)	63%
08	Administer inoculations, as directed by physician	(1)	13%	(8)	100%	(7)	88%
09	Administer medication, as directed by physician	(1)	13%	(8)	100%	(7)	88%
10	Prepare catheterization tray and assist in catheterization of patient	(2)	25%	(8)	100%	(7)	88%
Diagnostic Procedures/Equipment							
01	Take/record patient's weight and height	(6)	75%	(8)	100%	(8)	100%
02	Take/record patient's blood pressure, pulse rate	(6)	75%	(8)	100%	(7)	88%
03	Prepare/test EKG machine for proper, safe operation	(4)	50%	(4)	50%	(4)	50%
04	Prepare/instruct/assist patient for EKG machine	(3)	38%	(7)	88%	(5)	63%
05	Obtain EKG tracing; monitor for abnormal tracing	(2)	25%	(7)	88%	(5)	63%
06	Label/mount tracings	(4)	50%	(6)	75%	(5)	63%
07	Position/prepare patient for x-ray	(5)	63%	(7)	88%	(6)	75%
08	Take routine x-rays, per physician's orders	(2)	25%	(1)	13%	(1)	13%
09	Develop x-ray film	(3)	38%	(2)	25%	(2)	25%
10	Instruct patient in proper collection of specimen	(4)	50%	(8)	100%	(6)	75%

TABLE IX (Continued)

	Task	Credential CMA N	%	RN N	%	LPN N	%
Diagnostic Procedures Continued							
11	Collect urine/fecal specimen from patient	(6)	75%	(8)	100%	(7)	88%
12	Collect nose,throat specimen	(2)	25%	(8)	100%	(7)	88%
13	Prepare specimens for transport to laboratory	(5)	63%	(8)	100%	(7)	88%
14	Perform macroscopic examination of urine	(2)	25%	(1)	13%	(1)	13%
15	Centrifuge urine specimen sample	(3)	38%	(2)	25%	(2)	25%
16	Perform microscopic exam of urine	(1)	13%	(0)	0%	(1)	13%
17	Perform urinalysis dip stick test, i.e., sugar, albumin, acetone	(6)	75%	(6)	75%	(7)	88%
18	Perform specific gravity test on urine	(4)	50%	(4)	50%	(3)	38%
19	Determine/separate by method of sterilization items to be sterilized	(5)	63%	(4)	50%	(5)	63%
20	Wrap/sterilize instruments, equipment, material	(6)	75%	(4)	50%	(3)	38%
21	Obtain blood specimen from capillary, finger	(3)	38%	(5)	63%	(3)	38%
22	Obtain venous blood sample	(4)	50%	(7)	88%	(6)	75%
23	Perform diff cell count	(1)	13%	(0)	0%	(0)	0%
24	Perform white cell count	(1)	13%	(0)	0%	(0)	0%
25	Perform red cell count	(1)	13%	(0)	0%	(0)	0%
26	Perform hemoglobin/hct test	(1)	13%	(0)	0%	(0)	0%

*Number responding - 8

CHAPTER V

SUMMARY, FINDINGS AND RECOMMENDATIONS

SUMMARY

This study was primarily concerned with identifying how selected medical personnel perceive the different task-performing abilities of licensed versus certified allied health personnel in the State of Oklahoma, specifically the Northeast section.

Review of literature identified dissention among health professionals regarding the meaning of various credentials. The most widely accepted credenitals in the medical field today are licensure and certification. The primary differences in these titles existed only via the sponsoring agency. Licensure is granted by a government agency; certification is granted by nongovernmental or professional organization, with the certificate requiring a higher standard of requirements. Most licensing laws originated many years ago, thus, they are now obsolete and do not apply to present conditions of health care services (10).

Several national conferences (6, 12, 16, 21) have been held since 1970 to discuss the problems surrounding the credentialing of health personnel. A solution has not been found. However, certification has obtained national recognition by prominent members of the medical field (6).

Literature reviewed indicates there is a shortage of nursing personnel. The projected allied health manpower in 1980 indicates the necessity for more allied health personnel, specifically those with nursing skills (7). Emphasis was made throughout the literature that perhaps the greatest utilization was not being made of the present medical personnel. Nursing leaders have indicated they alone cannot provide the demands for health care. The Certified Medical Assistant does not receive training for "bedside" patient care; however, approximately 70 percent of skills obtained in school are "cross-occupational competencies." The lack of understanding of credentialing may in part be blamed on hostility, mistrust and self-interest among health professions (6, 10, 15, 18).

For purposes of this study, the health personnel identified on the questionnaire (task list) was limited to employees with "nursing" skills: the Registered Nurse, the Licensed Practical Nurse and the Certified Medical Assistant.

The target population for this study included family practitioners, hospital administrators and the directors of nursing services from eight cities in Northeast Oklahoma.

The questionnaire was developed by including the identified skills a Certified Medical Assistant, graduate of a two-year accredited program, could perform. The national test taken by the CMA includes questions regarding each skill listed. Many of these tasks, especially the laboratory skills - electrocardiograph skills as well as the radiology skills - are not included in the training received by the RN or LPN. However,

these individuals may be trained by the physician in the office or attend special seminars held on these subjects. These tasks were divided into three divisions: patient instruction, clinical assisting, and diagnostic procedures/ equipment. These divisions were utilized to provide easier readability for the reader.

Findings

The respondents were asked to check one or all categories of titles if he/she felt the task could be delegated to an individual with these credentials. The returns were tabulated and presented as percentages. The results were presented in Tables IV through IX. The respondents did not identify a perceived difference in most of the task-performing abilities of the licensed or certified allied health personnel.

Of interest, under patient instruction, task 8, several doctors added comments that this skill could only be performed by either the doctor or a dietitian. Perhaps, the statement was misunderstood. Many diet sheets are given to patients with various illnesses. The allied health personnel must make certain the patient understands the instructions given by the physician.

Some of the skills listed under diagnostic procedures, especially the tasks which involved obtaining and testing blood, received lower marks than the other identified tasks. There was a significant difference in task 24, performing red blood cell count and task 25, performing a red blood

cell count. Three tasks in the section on clinical assisting identified, via Cochran Q statistic, significant differences in the perception of task delegation to the title designates. These included task 8 which relates to administration of inoculations, as directed by the physician; task 9 which is administration of medication, as directed by physician and task 10, preparing catheterization tray and assisting in catheterization of patient.

Specifically, the study sought to answer the following questions:

1. Do family practitioners (M.D. and D.O.) perceive differences in the task-performing ability of certification versus licensure as identified by task designated to medical personnel holding differing titles?

Answer - Family practitioners do not perceive great differences in task-performing abilities by licensed versus certified allied health personnel with the exception of eight tasks identified by astericks in Table VIII. Additional comments regarding these tasks are discussed on the previous page.

Cochran Q statistical analysis was utilized to determine the significance of differences of the responses from the family practitioners. The Cochran Q value is listed in a column in Table VII with X_2 value given. The X_2 table value is 9.210 at the .01 level of significance with 2 degrees of freedom. Since eight of the calculated values were significant, the researcher was unable to totally reject the null

hypothesis that there is a significant difference in the task-performing abilities of licensed versus certified allied health personnel by this group of respondents. However, most of the tasks did not show a significant difference. These eight tasks have been identified in chapter four and chapter five.

It should be noted that only a Certified Medical Assistant receives the training in his/her educational process to perform all of the tasks identified on the questionnaire. Two respondents indicated that only a Licensed Practical Nurse could do any of the tasks listed. Perhaps the physician was relating the tasks to his/her particular office, or perhaps the medical personnel in the office completed the questionnaire. One physician identified several tasks that he felt a Registered Nurse or a Licensed Practical Nurse did not receive in his/her training; however, with training these individuals would be capable of performing these duties.

2. Do hospital administrators perceive differences in the task-performing ability of certification versus licensure as identified by tasks designated to medical personnel holding differing titles?

Answer - The hospital administrator identified the Registered Nurse as having the greatest responsibility in the performance of these tasks. In addition, these administrator's perceived the CMA (certified personnel) to be capable of performing more of the tasks than the Licensed Practical Nurse (licensed personnel).

3. Do directors of nursing services perceive differences in task-performing ability of certification versus licensure as identified by tasks designated to medical personnel holding differing titles?

Answer - The biases of the directors of nursing services were very obvious. The tabulated results were very one-sided on the majority of the tasks. Also, two respondents indicated they did not recognize the title CMA. As identified in the literature, the nursing profession feels threatened by entrance of any new association. However, because of the inability of this profession to meet all of the employment demands, Buzek (5) suggests a better distribution of health personnel. One physician from Tulsa wrote that he felt the RNs and LPNs did not obtain the education in their schooling to perform many of the tasks identified on the questionnaire. However, he also indicated that with training by the physician these skills could be obtained by this group of workers.

4. Does the size of the community affect the perception of the family practitioner with regard to the task-performing abilities of licensed versus certified allied health personnel?

Answer - The size of the community does not affect the perception of the family practitioner with regard to licensed or certified allied health personnel. The responses from the family practitioners in the three population sizes did not show a marked deviation in their ratings.

5. Does the size of the community affect the perception of the hospital administrator with regard to the task-perform-

ing abilities of licensed versus certified allied health personnel?

Answer - The null hypothesis was not tested on the hospital administrators' responses due to inadequate sample size being received. However, there was not a marked deviation in the responses of the administrators in varying sizes of communities.

6. Does the size of the community affect the perception of the directors of nursing services with regard to the task-performing abilities of licensed versus certified allied health personnel?

Answer - The null hypothesis was not tested on the responses of the directors of nursing services due to inadequate sample size being received. However, there was not a marked deviation in the responses of the nursing directors in varying sizes of communities.

Recommendations

The following recommendations are presented:

1. Information concerning certification and licensure should be made available to all allied health personnel, including physicians and hospitals. Conferences held in 1971 (16) indicated most allied health personnel fail to understand the concept of licensure and/or certification. This information should be incorporated within the educational setting.

2. Findings of this research should be presented to

local and state medical societies. This information can be presented to various health professions via seminars, staff meetings as well as state conventions.

3. Findings of this research should be presented to local, state and national Association of Medical Assistants.

4. The parent organization (American Association of Medical Assistants) as well as the state organization should work to clarify the term certification.

4. AAMA should strive for better communications with the other professions involved with "nursing" type skills.

At present, many Registered Nurses and Licensed Practical Nurses are members of AAMA. These individuals can provide information to their nursing organizations regarding the credential of certification. Meetings have been held with the nursing directors in the Tulsa area to urge establishing a job description for the Certified Medical Assistant. These individuals have been receptive to the idea; however, the hospital administrator and other nursing staff will need to be "sold" on this concept.

Recommendations for Further Studies

1. An in-depth study should be completed for all major cities in the State of Oklahoma with regard to credentialing of health personnel.

2. Further followup of national studies concerning credentialing of health personnel should be completed to obtain the current status of credentialing.

3. Interviews should be held with hospital administrators and the directors of nursing services to discuss credentialing of health personnel.

4. An in-depth study should be completed on the 50 medical practice acts in the United States. This study should identify similarities as well as differences for possible cohesion of these acts.

5. Studies should be completed on all credentialed health personnel to identify the "cross-occupational" skills as well as criteria for obtaining credentials.

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APPENDIXES

APPENDIX A

PANEL OF EXPERTS

Mrs. Kay Adams, CMA	Coordinator, Medical Assistant Program Tulsa Junior College
Mr. Omer Cowen, R.N.	Instructor, Nursing Program Tulsa Junior College
Dr. Waynne James	Associate Professor School of Occupational and Adult Education Oklahoma State University
Dr. James Key	Professor School of Agricultural Education Oklahoma State University
Dr. Clyde Knight	Associate Professor School of Occupational and Adult Education Oklahoma State University
Dr. Linda Vincent	Assistant Professor School of Occupational and Adult Education Oklahoma State University
Mrs. Bobbie Woodward, R.N.	Director, Handicapped/Safety Services Tulsa Junior College

APPENDIX B

QUESTIONNAIRE

Questionnaire Concerning
Perception of Different Credentialed
Health Personnel

The purpose of this study is to identify how selected medical personnel perceive certification versus licensure in the State of Oklahoma.

Please check the appropriate response to the following information.

1. Age: Under 30 ( ) 31-40 ( ) 41-50 ( ) 50+ ( )

2. Sex: Male ( ) Female ( )

3. Population of the city in which you live:

   a. 14,000 to 18,000 ( )

   b. 35,000 to 42,000 ( )

   c. 350,000+ ( )

4. If you are a physician, number of employees in your office:

   a. 1-4 ( )

   b. 5-9 ( )

   c. 10+ ( )

5. If you are a hospital administrator or director of nursing, number of employees in your hospital:

   a. 1-49 ( )

   b. 50-99 ( )

   c. 100-149 ( )

   d. 150-199 ( )

   e. 200+ ( )

The following questionnaire contains numerous tasks that can be delegated to health personnel. Please check in appropriate column indicating health personnel to which each task could be delegated according to the individual credentials. (If the task could be delegated to all three, please mark all three groups).

	CMA	RN	LPN
Ex; Measure, record patient's weight & height	(x)	(x)	(x)

CMA - Certified Medical Assistant
LPN - Licensed Practical Nurse
RN - Registered Nurse

Please answer each item. Your time and cooperation is greatly appreciated.

Task Descriptors for Clinical Responsibilities

Patient Instruction	CMA	RN	LPN
01 Instruct patient in examination preparation	( )	( )	( )
02 Instruct patient in preparation for lab tests ordered by the physician	( )	( )	( )
03 Instruct patient how to prepare for x-ray procedures	( )	( )	( )
04 Verify/repeat physician's instructions for confused patient	( )	( )	( )
05 Instruct patient in care of incision/wound	( )	( )	( )
06 Instruct patient in how to change dressing	( )	( )	( )
07 Instruct patient as how to wrap elastic bandage	( )	( )	( )
08 Discuss and instruct diet/nutrition therapy	( )	( )	( )
Clinical Assisting			
01 Prepare/drape patient for examination	( )	( )	( )
02 Explain examination procedure to patient, i.e., gynecological, proctological	( )	( )	( )
03 Position patient for examination	( )	( )	( )

Continued next page

Clinical Assisting Continued:

		CMA	RN	LPN
04	Prepare treatment room/tray for minor surgery	( )	( )	( )
05	Assist physician in minor surgery	( )	( )	( )
06	Apply/remove surgical bandaging, as directed by physician	( )	( )	( )
07	Remove sutures, as directed by physician	( )	( )	( )
08	Administer innoculations, as directed by physician	( )	( )	( )
09	Administer medication, as directed by physician	( )	( )	( )
10	Prepare catheterization tray and assist in catheterization of patient	( )	( )	( )

Diagnostic Procedures/Equipment

01	Take/record patient's weight and height	( )	( )	( )
02	Take/record patient's blood pressure, pulse rate, respiration rate	( )	( )	( )
03	Prepare/test EKG machine for proper, safe operation	( )	( )	( )
04	Prepare/instruct/assist patient for EKG exam	( )	( )	( )
05	Obtain EKG tracing; monitor for abnormal tracing	( )	( )	( )
06	Label/mount tracings	( )	( )	( )
07	Position/prepare patient for x-ray	( )	( )	( )
08	Take routine x-rays, per physician's orders	( )	( )	( )
09	Develop x-ray film	( )	( )	( )
10	Instruct patient in proper collection of specimen	( )	( )	( )
11	Collect urine/fecal specimen from patient	( )	( )	( )
12	Collect nose, throat specimens	( )	( )	( )

Continued next page

Diagnostic Procedures/Equipment Continued:

	CMA	RN	LPN
13 Prepare specimens for transport to laboratory	( )	( )	( )
14 Perform macroscopic examination of urine	( )	( )	( )
15 Centrifuge urine specimen sample	( )	( )	( )
16 Perform microscopic examination of urine	( )	( )	( )
17 Perform urinalysis dip stick test, i.e., sugar, albumin, acetone	( )	( )	( )
18 Perform specific gravity test on urine	( )	( )	( )
19 Determine/separate by method of sterilization items to be sterilized	( )	( )	( )
20 Wrap/sterilize instruments, equipment, material in autoclave	( )	( )	( )
21 Obtain blood specimen from capillary, finger	( )	( )	( )
22 Obtain venous blood sample	( )	( )	( )
23 Perform differential cell count	( )	( )	( )
24 Perform white blood cell count (WBC)	( )	( )	( )
25 Perform red blood cell count (RBC)	( )	( )	( )
26 Perform hemoglobin/hematocrit test	( )	( )	( )

Thank you for taking the time to complete this questionnaire.

APPENDIX C

COVER LETTERS

Oklahoma State University
SCHOOL OF OCCUPATIONAL AND ADULT EDUCATION

STILLWATER, OKLAHOMA 74078
CLASSROOM BUILDING 406
(405) 624-6275

January 1, 1983

Dear

In the interest of improving medical assistant education programs we are asking your help in a study designed to obtain information relevant to credentials held by medical personnel in the State of Oklahoma. At present, three major credentialing instruments are awarded to graduates of accredited health programs who successfully pass a national or state examination.

A stamped, self-addressed envelope is enclosed for your convenience. Confidentiality will be carefully guarded.

The research findings should be available by May 1, 1983. Call or write me if you would like to have a copy.

Your assistance in this research will be deeply appreciated.

Sincerely,

Jeanette Girkin

Jeanette Girkin
Graduate Student
Oklahoma State University

Enclosures - 2

Oklahoma State University

SCHOOL OF OCCUPATIONAL AND ADULT EDUCATION

STILLWATER, OKLAHOMA 74078
CLASSROOM BUILDING 406
(405) 624-6275

January 18, 1983

Dear

Recently you received a questionnaire concerning perceptions of credentialing health personnel. I would like to be able to include your opinion in the research results.

Therefore, will you take a few minutes to complete and mail this questionnaire.

Thank you for taking the time.

Sincerely,

Jeanette Girkin

Jeanette Girkin
Graduate Student
Oklahoma State University

VITA

Gwendolyn Jeanette Girkin

Candidate for the Degree of

Doctor of Education

Thesis: STUDY OF THE PERCEPTION OF CERTIFICATION VERSUS LICENSURE AS VIEWED BY MEDICAL PERSONNEL IN NORTHEAST OKLAHOMA

Major Field: Occupational and Adult Education

Bibliography:

Personal Data: Born in Owasso, Oklahoma, September 27, 1931, the daughter of Russell and Inez Kauffman

Education: Received GED in 1967; received Associate Degree in Liberal Arts from Tulsa Junior College in May 1976; received the Bachelor of Science in Trade and Industrial Education degree from Oklahoma State University in May, 1978; completed requirements for the Master of Science degree with a major in Trade and Industrial Education, from Oklahoma State University in December, 1979; enrolled in doctoral program at Oklahoma State University in January 1980; completed requirements for the Doctor of Education degree in Occupational and Adult Education at Oklahoma State University in May 1983.

Professional Experience: Medical Secretary at Hillcrest Medical Center, Tulsa, Oklahoma 1965-67; Medical Transcriptionist and Director of Tumor Registry, St. John's Hospital, Tulsa, Oklahoma 1967-69; Director of Medical Record Department, Doctor's Medical Center, 1969-71; Coordinator Medical Assistant Program, Tulsa Junior College 1971-present.

Professional Organizations: American Medical Record Association; American Association of Medical Assistants; Tulsa Junior College Faculty Association; FOCUS