

Closing the Gap Between Military Medical
Personnel and their Civilian Counterparts:
A Possible Solution to the Expanding Nurse
Shortage in the United States

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I. INTRODUCTION

For more than a century, the exemplary performance standards and heroic personnel of the United States Navy's Hospital Corps has made it the most decorated institution in the United States military.¹ The training that the enlisted individuals undergo in order to develop their skills is stanch and brutal;² yet, battlefield medicine, as vital as it may seem in the fog and chaos of war, does not typically find itself present and applicable in everyday civilian life.³ Due to the limited overlap between the training that

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1. See Jason Kelly, *Navy Hospital Corps Celebrates 115 Years of Service*, NAVY LIVE (June 17, 2013, 12:20 PM), <http://navylive.dodlive.mil/2013/06/17/navy-hospital-corps-celebrates-115-years-of-service/> (providing facts about the Navy Hospital Corps, including that 178 corpsmen have received the Navy Cross); U.S. Navy Bureau Med. & Surgery Pub. Affairs, *Navy Surgeon General Honors Hospital Corps' 113th Birthday*, AMERICA'S NAVY (June 15, 2011), http://www.navy.mil/submit/display.asp?story_id=61029 ("The Hospital Corps is the largest rating in the Navy and the most decorated in the U.S."); e.g., See Mark T. Hacala, *The U.S. Navy Hospital Corps: A Century of Tradition, Valor, and Sacrifice*, NAVY MED., May-June 1998, at 25-26, available at <https://archive.org/stream/NaVymedicineVol.89No.3May-june1998/NavyMedicine1998-05#page/n1/mode/2up/search/Hacala> ("Today, the 23,000 regular and 6,000 reserve members of the Navy Hospital Corps continue to serve around the globe. . . . They maintain constant battle readiness with Marine Corps units and SEAL teams.").

2. See *infra* text and accompanying notes 29-30 (outlining the basic training that corpsmen and other military medical personnel complete).

3. E.g., MOST FREQUENCY PROCEDURES PERFORMED IN U.S. HOSPITALS, 2010, AGENCY FOR HEALTHCARE RESEARCH & QUALITY 2-3 (2010), available at <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb149.pdf> (stating the top medical and surgical procedures performed in the U.S. in 2010, most of which would not be considered battlefield medicine).

corpsmen obtain while in service and the treatment that civilian medical personnel are expected to provide, many of these soldiers return home from service, hoping to apply their skills and medical knowledge to a permanent profession, but find their qualifications lacking.⁴ Meanwhile, the United States faces a continuous shortage of nurses and additional general medical care providers to treat a rapidly aging population.⁵

The issue of veterans struggling to find work once they have completed their military service is far from a new matter for the United States,⁶ but it does not mean that the problem is impossible to fix.⁷ Both Congress and many state legislatures recognize the issues facing our veterans returning to the work force, and they continue to attempt to put forth strategies ranging from increasing the hiring rates of veterans,⁸ to providing better training and education to soldiers while in the military in order to smooth the transition from active service.⁹ Of these governmental bodies, the state of California

But see Sandra Basu, *Military Trauma Advances Also Help Civilians, Must be Maintained*, U.S. MED., (Sept. 2013), <http://www.usmedicine.com/articles/military-trauma-advances-also-help-civilians-must-be-maintained.html#.Up9qucRDskQ> (discussing the many major advancements in civilian trauma treatment that can be attributed to military medicine training and procedures).

4. See Ed Michaud, et al., *Assessment of Admissions Policies for Veteran Corpsmen and Medics Applying to Physician Assistant Educational Programs*, 23 J. PHYSICIAN ASSISTANT EDUC. 4, 6 (2012) (conducting research that showed that out of 110 PA programs, military veterans were admitted to 83.6% of them during 2008–2010, resulting in 2.7% of the total enrollment in these PA programs in 2009; 2.3% in 2009; and 2.8% in 2010).

5. See *Nursing Shortage*, AM. NURSING ASS'N, <http://www.nursingworld.org/nursingshortage> (last visited Dec. 4, 2013) (discussing the reasons for the continual shortage of nurses and the potential positive and negative consequences of the shortage).

6. E.g., Joan Goldstein, *Medical Corpsmen as a Source of Civilian Health Manpower for New Jersey*, 8 MED. CARE 254, 254, 256–258 (explaining the recognition of the need to help employ veteran corpsmen after the Vietnam War in New Jersey as well as several of the programs that were set forth as a result).

7. See *infra* Part IV (describing many of the established programs that attempt to resolve issues surrounding the transition of medical veterans into civilian care positions).

8. See *infra* Part IV (explaining some of the current legislation and bills in both the federal government and state governments respectively).

9. See William L. Kissick, *Health Manpower in Transition*, 46 MILBANK MEM'L FUND Q. 53, 83 (1968), available at <http://www.jstor.org/discover/10.2307/3349149?uid=3739256&uid=2&uid=4&sid=21102706902113> ('The experience of the armed forces in preparing hospital corpsmen, laboratory technicians and personnel for other health

has taken the most prominent steps in this area.¹⁰ The steps that California took and the laws and policies enacted provide a surmountable template for other states to follow in the quest to support returning veterans of the Hospital Corps.

The goal of this article is to propose a strategy for states to provide opportunities for these specific veterans by following in the footsteps of California's legislation and policies. In Section II, this article will provide a brief history of the United States Hospital Corps and its progression towards present day standards.¹¹ Then, Section III will explain the modern medical training and scopes of practice of corpsmen, their civilian counterparts, and the issues arising from the discrepancies between the two.¹² Finally, Sections IV and V advocate that this system will provide a reasonable and helpful solution to the shortage of nurses and other medical providers, and will allow this country to take care of the individuals that it owes the most to: the brave men and women of the military forces.¹³

II. BACKGROUND¹⁴

The first military medical positions were remarkably simple and left

occupations suggests that career ladders in health are feasible . . ."); *see also infra* notes **Error! Bookmark not defined.**–**Error! Bookmark not defined.** and accompanying text (providing examples of educational institutions that have already begun to adapt to corpsmen education levels and are changing their programs to accommodate for them).

10. *See infra* Part IV (describing several of the progressive steps taken by California in easing the transitions of medical veterans).

11. *See infra* Part II (summarizing the historical development of the Navy medical personnel).

12. *See infra* Part III (discussing the scopes of practice of both modern corpsmen and several common medical provider positions, and the discrepancies between the two).

13. *See infra* Part IV–V (proposing a system, primarily based on California, for states to follow in order to provide adequate opportunities to veteran corpsmen).

14. While this section will primarily focus on the history of the Navy's medical personnel and corpsmen, stories of other military medical personnel that could not be included in this article can be found elsewhere. For example, for a description of the history of the Army nurse, see generally MARY T. SARNECKY, A HISTORY OF THE U.S. ARMY NURSE CORPS I (University of Pennsylvania Press, 1999).

more to luck than to the actual application of treatment.¹⁵ While these individuals were technically enlisted in the military, there was not an official title or description of enlisted medical personnel.¹⁶ During this time, the range of possible care, either in the medical ward or on the battlefield, was incredibly limited by the available technology and the lacking of anatomical and physiological knowledge.¹⁷ With the start of the American Civil War, the Navy demanded an increase in its medical sectors to provide care to its rapidly increasing number of soldiers.¹⁸ After the conclusion of this war, the Navy reduced and concentrated its medical corps and also increased the required qualifications for enlistment as medical staff personnel.¹⁹ Ultimately, due to tremendous pressure from naval physicians, as well as the impending Spanish-American War, President William

15. HACALA, *supra* note 1, at 12. These original positions were created out of necessity during the Revolutionary War, and generally consisted of three person groups that were made up of a surgeon, a surgeon's mate, and usually an enlisted soldier. *Id.* A practicing physician held the surgeon position, while the surgeon's mate would be more comparable to that of a modern day corpsmen in responsibilities and knowledge. *Id.*

16. HACALA, *supra* note 1, at 12. The first recorded title for an enlisted military medical provider was "loblolly boy," which described the non-professional assistant to the unit's surgeon. *Id.* The title originated from one of the primary duties of these individuals, which was to serve the patients loblolly—a thick porridge with meat or vegetables. *Id.*

17. *Id.* There was realistically a minimal advancement, if any at all, in medical treatment and techniques between the end of the Revolutionary War and the first decades of the nineteenth century. *Id.* In fact, medical tents, buildings, and wards were considered more of a place to die than as a place to heal. *Id.* The most common "care" that was provided to the wounded and sick was a daily ration of porridge or "loblolly." *Id.* (describing the extremely limited options for treatment and care by medical personnel in the late 1700's).

18. *Id.* The Navy's answer for this new demand was the allowance of a new position on ships and smaller vessels: the military nurse. *Id.* at 13 ("In addition to a surgeon's steward, 1 nurse would be allowed for ships with a complement of less than 200; 2 nurses would be allowed for ships with a complement of more than 200; and sufficient nurses would be allowed on receiving ships in a number proportionate to the necessities of the vessel.") (quoting *Hospital Corps, U.S. Navy*, Hosp. Corps Q., April–June 1948, at 21(2):2.)).

19. *Id.* at 16. This increase of educational standards continued into the final decades of the nineteenth century, eventually challenging the Navy to keep up with the Army, who had officially established its own Hospital Corps in 1887 and began training its medics in civilian hospitals. *Id.* Along with the advancement of qualifications, the Navy changed the titles of personnel, including the surgeon's steward into three separate grades of apothecaries in 1866, all of which were required to have a basic knowledge of pharmacy, and making and dispensing all medication necessary for a specific ship. *Id.* at 15.

McKinley signed into law the creation of the Navy Hospital Corps on June 17, 1898.²⁰

The newly established Hospital Corps brought with it a new degree of educational and procedural standards.²¹ The end of World War I led Congress to enact a new law that refined the classes of the corps, and increased the overall size of the Navy Hospital Corps five-fold.²² This increase in medical personnel hit its peak in World War II, when the number of enlisted Hospital Corps members reached a staggering 132,000 individuals.²³

After World War II, the modern day Hospital Corps began to take shape as new legislation brought large changes to the organization.²⁴ The practice

20. *Id.* at 16 (explaining the process of forming the Navy Hospital Corps). The system of identification of medical personnel as corpsmen, and the separation of that title into three separate classes, which was set forth in that law still stands to the present day. *See id.* (explaining the hospital apprentice, hospital apprentice first class, and the hospital steward positions).

21. *E.g. id.* at 17 (“[The new] curriculum included anatomy and physiology, bandaging, nursing, first aid, pharmacy, clerical work, and military drill. . . . Development of the Navy’s hospital corps training courses would prepare the first generation of hospital corpsmen for arduous duty, both in peace and war.”). To fulfill these new standards, the Navy founded the first “school of instruction” as a part of the U.S. Naval Hospital Norfolk. *Id.* at 16–17.

22. *Id.* at 17, 19 (stating that by the end of World War I, the number of enlisted soldiers in the Hospital Corps would peak at 17,000). The Navy’s corpsmen became so prevalent, that they were even sent to help in other branches of the military, including the front-lines with the Marine Corps. *Id.* at 19. Those corpsmen specially trained in the practice of treating trauma victims for as long as it took before they transportation to proper health care facilities was available. *Id.*

23. *Id.* at 20. Along with the growth in sheer man power, corpsmen were also continuously applying the most recent medical technology and treatment methods to their patients, sometimes even before they had been performed in civilian medicine in the United States. *See generally* Keely Grasser, *Military Medicine: A History of Innovation*, PHOENIX PATRIOT, Winter 2012, <http://phoenixpatriotmagazine.com/article/winter12/> (describing the many medical advancements achieved by the military).

24. *E.g., id.* at 21 (discussing the consequences of the legislative acts after World War II, including the establishment of the Department of Defense, the removal of commissioned allied health and medical officers from the Army and Navy Hospital Corps, creation of a separate dental technician class, and finally another change to the titles and rankings of the Hospital Corps). This movement was highlighted by the allowance of women to enlist in military service and become active medical corpsmen. *Id.* Although women were not officially allowed to enlist in military service, many women were enrolled in the Women’s Reserve, or “WAVES”, of the Hospital Corps. *Id.* at 21–22.

capabilities of corpsmen continued to advance and become more sophisticated during the Vietnam War, eventually to the extent that civilian hospitals began to recognize the benefit of having an individual with this extensive medical knowledge available, even without a medical school degree.²⁵ Veteran corpsmen came back to the United States after the Vietnam War and started working as a new type of medical provider, known today as a physician's assistant.²⁶

However, the days of corpsmen leading the way in the practice of innovative techniques and use of advanced technology quickly vanished as the demands within the field of medicine and the knowledge of new treatment and sciences exploded over the remaining decades of the twenty-first century.²⁷

25. See *infra* note 26 and accompanying text (claiming that, regardless of the fact that they did not have a formal medical education, military corpsmen were the ideal candidate on which to base the new physician assistant position).

26. Reginald Carter, *Physician Assistant History*, 12 PERSP. ON PHYSICIAN ASSISTANT EDUC. 130, 130–32 (2001). The idea of utilizing corpsmen in civilian hospitals originated at Duke University by Dr. Charles L. Hudson, who had the idea of quelling the shortage of medical providers by creating two new types of assistants in medical institutions. *Id.* The first would be trained on-the-job to “serve in medical and surgical inpatient divisions, the operating room, and emergency ward,” and whose duty was compared directly to that of a corpsmen. *Id.* The second assistant was expected to have more specialization and education, and in practice would be considered more of an intermediate between a physician and a technician. *Id.* The first wave of these new assistants was made up entirely of veteran corpsmen. *Id.* The position soon received the recommendation of the American Medical Association, as several States began to incorporate the assistants into the medical field. *Id.* However, issues arose regarding the extent of treatment and practice that these ex-corpsmen could legally have and still loom today as the practice of medicine continues to become more precise while the population, and thus the demand for healthcare providers, grows. *Id.*

27. Cf. *The 1960s: Medicine and Health: Overview*, ENCYCLOPEDIA.COM, <http://www.encyclopedia.com/doc/1G2-3468302401.html> (discussing the transformation in medical knowledge and treatment, mostly by researchers in civilian care, after World War II). These new standards for civilian medical providers would limit the options of veteran corpsmen returning from service as they demanded higher education for the same positions that were at one point based on the corpsmen position. *Id.* The gap of knowledge and skill between civil medical personnel and their military counterparts had officially been established and has been widening at a remarkable rate ever since. See *infra* Part III (comparing the scopes of practice of modern corpsmen and several common healthcare positions).

III. DISCUSSION

The modern scopes of practice for military medical personnel provide clear discrepancies in knowledge, skill, and priority between them and their civilian counterparts.²⁸ However, before any changes can be proposed on either the state or federal level to remedy these discrepancies, it is first essential to understand the current training and scopes of practice of medical corpsmen, as well as recognize the variance between these military medical personnel and their civilian counterparts.

Individuals that enlist in the Hospital Corps must complete a demanding curriculum and training in order to become licensed medical personnel in the military.²⁹ However, the present day Navy or Army corpsman possess a limited scope of practice consisting primarily of battlefield treatment

28. See e.g. Kathryn J. Krause, *An Analysis of First Duty Station Placement and New Graduate Transition Education and Retention in the Navy Nurse Corps* (March 2010), (unpublished M.A. thesis, Naval Postgraduate School), available at <http://hdl.handle.net/10945/5408>. Other than a two-year course and the experience obtained from actual practice, military medical personnel do not receive any other form of medical training, especially in connection with civilian care. E.g., *id.* at xiii (“Nursing research indicates that new graduate nurses . . . do not possess the clinical abilities, critical thinking skills, and professional acumen to perform at the level of an experienced nurse.”); *id.* at 73 (“There is no standardized . . . transition program throughout the Navy. . . . None of the programs contain all of the essentials recommended in nursing research and professional literature.”).

29. See MELISSA KNOX, CATHERINE DOWER, & EDWARD O’NEIL, *US MILITARY AND CALIFORNIA HEALTH PERSONNEL: SELECT COMPARISONS 5–6* (2008) [hereinafter *COMPARISONS*], available at http://futurehealth.ucsf.edu/Content/29/2008-02_US_Military_and_California_Health_Personnel_Select_Comparisons.pdf (describing the common training provided to military medical recruits). After graduating high school, individuals are required to complete a two-year program consisting of a brief overview of anatomy and physiology, medical treatment techniques, methodology of administering certain drugs, and emergency and trauma care; all to the limited extent that future military medical personnel will need to be successful in service. *Id.* After this course, the recruits attend a year of regular soldier protocol and physical training. *Id.* Finally, the recruits are distributed to chosen or assigned locations and begin to accumulate clinical experience in their specific fields. Cf. *Veterans’ Employment: Improving the Transition from the Battlefield to the Workforce Before S. Veterans Affairs Comm.*, 112th Cong. (2011) (testimony of Eric Smith, Iraq and Afghanistan Veterans of America) [hereinafter *Eric Smith Testimony*], available at http://www.veterans.senate.gov/hearings.cfm?action=release.display&release_id=4983bc21-69b3-4024-9558-3bf2ad6df9ac (“As a Navy Corpsman, I carried enormous responsibility and acquired a wide range of technical and leadership skills that should translate into a good job in the civilian workforce. . . . By age 19, I had skills, training and responsibilities far beyond those of my civilian peers in the medical field.”).

techniques, basic trauma surgery, and a narrow range of knowledge involving prescription drugs, mainly focusing on pain inhibitors and trauma medication.³⁰ The level of care which corpsmen can provide depends on local regulations and guidelines, and it is generally very restricted.³¹ The limitations of a corpsman's scope of practice lies directly with the fact that the medical education that these soldiers receive is deficient in regards to civilian healthcare education, both in the specific content and extent of experience.³²

The gap of treatment, technique, and knowledge between civilian and military care providers is the primary inhibitor of veteran medical personnel obtaining healthcare careers when they leave the service.³³ This discrepancy becomes more apparent when the scope of practice of corpsmen is directly compared to the civilian positions in which medical veterans pursue.³⁴ Corpsmen veterans that wish to transition to civilian

30. NAVY MEDICINE MANPOWER, PERSONNEL, TRAINING, AND EDUCATION COMMAND, HOSPITAL CORPSMAN: NAVEDTRA 14295B: NON-RESIDENT TRAINING COURSE 1-1 (2010) [hereinafter NRTC], available at <http://www.navybmr.com/study%20material/NAVEDTRA%2014295B.pdf>.

31. See NRTC, *supra* note 30, at 11-2 (outlining the professional aspects to the corpsmen profession, including the professional responsibilities and limitations). Even in the military's own hospitals, corpsmen take on more of an assistant role in the clinical setting. *Id.* They are generally confined to "administering medication, performing treatments, and providing individual patient care in compliance with the orders of the senior healthcare provider." *Id.* Even though they are only assistants to the overall procedure, hospital corpsmen are still held to the highest standard of responsibility for their actions during the medical procedure. *Id.* at 11-2 to 11-3.

32. Compare *A Brief Synopsis of Medical School—Medical School Requirements*, PETERSON'S (Jan. 30, 2013), <http://www.petersons.com/graduate-schools/synopsis-medical-school-requirements.aspx> (summarizing the modern medical school experience and demands), with *supra* note 29 and accompanying text (summarizing the general requirements for corpsman education). The educational differences between corpsmen and civilian medical providers are a clear show the tremendous gap between the material and treatments taught to corpsmen compared to those civilian positions. *Id.*

33. See COMPARISONS, *supra* note 29, at 9–10 ("Despite the numerous potential opportunities for individuals separating from the military . . . many differences exist between the military and civilian health care sectors that may have an impact on career transitions . . .").

34. Compare *supra* Part III (describing the scope of practice and required training for modern corpsmen) with *infra* notes 36–40 and accompanying text (summarizing the scopes

health care generally favor positions that have similar responsibilities to those they had as a corpsman.³⁵ These positions mainly consist of emergency medical technicians (EMTs),³⁶ licensed vocational nurses (LVNs),³⁷ registered nurses (RNs),³⁸ nurse practitioners (NPs),³⁹ and

of practice for the most prevalent professions for medical veterans in civilian healthcare).

35. Cf. AM. ACAD. PHYSICIAN ASSISTANTS, PHYSICIAN ASSISTANT CENSUS REPORT: RESULTS FROM THE 2010 AAPA CENSUS 12 tbl.11 (2010), available at http://www.aapa.org/uploadedFiles/content/Research/2010%20Census%20Report%20National%20_Final.pdf (showing that approximately 4.4% of current practicing PAs have some affiliation with a military entity or the VA).

36. See, e.g., NATION EMS SCOPE OF PRACTICE MODEL, NAT'L HIGHWAY TRAFFIC SAFETY ADMIN. 23–24 (February 2007), available at <http://www.nremt.org/nremt/downloads/Scope%20of%20Practice.pdf> (“[An EMT’s] scope of practice includes basic, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, [EMTs] provide care to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an emergency care facility.”).

37. E.g., LICENSED VOCATIONAL NURSE SCOPE OF PRACTICE STANDARDS, CAL. CORR. HEALTH SERV. 5-5-1 to 5-5-6 (January 2002), available at <http://www.cphcs.ca.gov/docs/imspp/IMSPP-v05-ch05.pdf>. Compared to the more independent positions, LVNs are expected to have a different role in the patient treatment, mainly centered on obtaining an assessment of the patient’s basic physical and mental states. *Id.* (defining what a “basic” assessment of assigned patients would consist of for an LVN, including the collection of “subjective and objective [physical] data and recognition of problems or abnormal conditions,” and a psychosocial assessment of a patient). The degree of this assessment is not allowed to include any aspect that could be considered medical treatment. See *id.* at 5-5-2 to 5-5-6 (describing the basic allowances for LVN practice in a hospital, specifically in California).

38. E.g., CAL. DEP’T. CONSUMER AFFAIRS BOARD OF REGISTERED NURSING, AN EXPLANATION OF THE SCOPE OF RN PRACTICE INCLUDING STANDARDIZED PROCEDURES 1 (January 2011), available at <http://www.rn.ca.gov/pdfs/regulations/npr-b-03.pdf> (explaining the scope of practice of California RNs according to the Nursing Practice Act, Business and Professions Code § 2725). The ability to provide actual medical treatment does not truly begin until an individual reaches the point of RN. *Id.* In general, RNs are legally allowed to diagnose mental and physical conditions, administer pharmaceuticals to patients, perform the most basic forms of surgery that breach the tissue of patients in order to treat conditions, and to perform most any additional actions in order to insure the safety and comfort of the patient during their stay. See *id.* at 2 (providing a list of the common functions that RNs are permitted to perform).

39. See SCOPE OF PRACTICE FOR NURSE PRACTITIONERS, AM. ASS’N NURSE PRAC. 1 (2013), available at <http://www.aanp.org/images/documents/publications/scopeofpractice.pdf> (outlining the general guidelines and recommendations for States to consider when enacting their own scope of practice laws for NPs). An NP’s scope of practice includes full diagnosis and disease management of acute and some chronic illnesses, laboratory test ordering and interpretation, and even the ability to prescribe certain medications and non-pharmacologic therapies. *Id.* NPs are technically capable of prescribing certain pharmaceuticals, but they must first register with the United States Drug

physician assistants (PAs).⁴⁰

This gap is even more prevalent in the licensure requirements for civilian medical personnel, which do not recognize the experience and education that the military provides corpsmen.⁴¹ Moreover, veterans that attempt to seek licensure to practice medicine as any of the professions mentioned below, find that the information and knowledge required by the state licensing exams is far from that which they learned through the Hospital Corps.⁴² These individuals are inevitably forced to undergo the same level

Enforcement Administration, and even then, are usually only allowed to prescribe Schedule II controlled substances. See Board of Registered Nursing, *General Information: Nurse Practitioner Practice*, CAL. DEP'T. CONSUMER AFF. 2-3 (April 2011), available at <http://www.rn.ca.gov/pdfs/regulations/npr-b-23.pdf> (describing the controlled substance furnishing policies for NPs).

40. See 263 MASS. CODE. REGS. 5.04 (2013), available at <http://www.mass.gov/eohhs/docs/dph/regs/263cmr005.pdf> (stating the regulations of PAs for Massachusetts); e.g., AM. ACAD. PHYSICIAN ASSISTANTS, PROFESSIONAL ISSUES: PHYSICIAN ASSISTANT SCOPE OF PRACTICE 1 (October 2011), available at http://www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/PI_PAScopePractice_110811_Final.pdf (“The boundaries of each PA’s scope of practice are determined by four parameters: education and experience; state law; facility policy; and the supervising physician’s delegatory decisions.”). The general scope of practice for PAs consists of the performance of any medical procedure that is deemed permissible by the supervising physician and is within the competency of the PA, the treatment of any patient, regardless of age and condition, as deemed acceptable by the supervising physician, and any treatment or procedure within a PA’s designated specialty that is consistent with the first two components. *Id.* PAs also have the ability prescribe controlled substances to patients with the authorization of the supervising physician, but unlike NPs, PAs can become authorized to prescribe up to Schedule V drugs depending on the state’s allowance. See AM. ACAD. PHYSICIAN ASSISTANTS, PA PRESCRIBING AUTHORITY BY STATE (July 2013), available at http://www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/Rx%20Chart%207-13.pdf (providing the range of controlled substances that many states allow PAs to prescribe).

41. See COMPARISONS, *supra* note 29, at 10 (stating that civilian health institutions and state licensing boards do not recognize education, training, and experience obtained in the military); e.g., *Eric Smith Testimony*, *supra* note 29 (stating that Navy corpsmen, even if they believe they are overqualified for the position, are not able to obtain positions as civilian nurses and thus consider their “graduation from Naval Hospital Corps school and years worth of experience” resulted in “no certifications that translated into the civilian world”).

42. See, e.g., Philip K Ireland, *MiraCosta Class Targets Military Folks in Transition*, SAN DIEGO UNION-TRIB., Mar. 4, 2008, <http://www.utsandiego.com/news/2008/mar/04/miracosta-class-targets-military-folks-in/all/?print> (describing a course offered by MiraCosta College in California that prepares medical veterans to challenge the LVN examination to become a licensed LVN). Another large hindrance for veterans seeking to obtain their

of education and clinical experience as regular civilians that enter the field without any medical exposure.⁴³ California is one of the few states that is leading a change to not only recognize the military experience of these medical personnel when considering licensure, but to provide these veterans an accelerated path based on their experience.⁴⁴ Other states must look towards the progressive steps taken by California in providing a more accommodating transitory environment for corpsmen.

IV. ANALYSIS

Between the inconsistency in medical education and the absence of recognition for military experience, a vast majority of veterans find themselves back to square one in their paths of becoming civilian medical providers.⁴⁵ While these obstacles for United States' veterans caught the

medical license is the excessively varied requirements and expectations from different states in their licensure measures. *Id.* Furthermore, because these licensing standards are set by the states themselves, the military cannot replicate them for their own standards, thus creating an even smaller consistency between civilian and military care. *Id.* For an overview of the licensing requirements for LVNs, RNs, NPs, and other medical professions, see CAREERONESTOP, http://www.careerinfonet.org/LicensedOccupations/lois_agency.asp?stfips=99&nodeid=16&by=occ&jobfam=29&onetcode=29-2061.00&onetcode=29-1071.00&onetcode=29-1141.00 (last visited Sept. 28, 2013).

43. See Mary Wakefield, *Helping Veterans Transition to Careers in Nursing*, VANTAGE POINT: DISPATCHES FROM THE U.S. DEP'T VETERANS AFFS. (September 21, 2011), <http://www.blogs.va.gov/VAntage/4668/helping-veterans-transition-to-careers-in-nursing/> (“[V]eterans have found that their training in medic and certain other health care roles do not fully meet the standards of academic training for nursing programs. As a result, Veterans have encountered difficulty gaining academic credit for their health care training while enlisted.”). But see Patricia Allen et al., *Returning Enlisted Veterans—Upward (to) Professional Nursing: Not All Innovative Ideas Succeed*, 28 J. PROF. NURSING 241, 243 (2012) (“U.S. Army LVNs are often able to readily find employment soon after leaving the military. . . . The military LVN is often overqualified for the civilian LVN position, yet underqualified for other health care positions.” (citing COMPARISONS, *supra* note 29)).

44. *E.g.*, CAL. BD. OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS, INSTRUCTIONS TO APPLICANTS FOR LICENSURE AS A LICENSED VOCATIONAL NURSE 3 (2009), available at <http://www.bvnpt.ca.gov/pdf/method4.pdf> (permitting individuals to present record of military service in order to qualify to challenge the LVN exam); *supra* note 42 and accompanying text (discussing the college course offered by MiraCosta College which prepares veteran corpsmen to prepare to challenge the LVN exam and become licensed in California).

45. See, e.g., COMPARISONS, *supra* note 29, at 10 (explaining that the because the scopes of practice differ so dramatically between civilian care and military care, veterans struggle to

attention of the federal government and a few states, resulting in limited programs and legislation, the state of California went a step further by enacting a true change to this transitory process.⁴⁶

On the federal level, several bills were proposed that include a strong motivation to increase the number of jobs available to veterans as well as to help train them, either during their service or afterwards, to be successful in their chosen careers.⁴⁷ Furthermore, President Barack Obama takes a strong stand for veteran transitional efficiency,⁴⁸ and has created a new executive body to help train and place veterans into a variety of careers, including healthcare positions.⁴⁹ President Obama's effort has been bolstered by many

should that they're qualified); *Eric Smith Testimony*, *supra* note 29 ("In the military I was more than qualified for the positions I applied for in the civilian workforce. But in the civilian world, my military education and training did not translate because I didn't have a piece of paperwork saying so.").

46. See *infra* Part IV (explaining several recent laws and programs that are promoting efficient transitions for corpsmen, nurses, and medics into equivalent civilian healthcare professions).

47. See, e.g., 10 U.S.C. § 1144 (2011) (authorizing funding and program development for the Secretary of Labor, Defense, Homeland Security, and of Veteran Affairs to promote more efficient veteran transitions in the civilian work force); National Defense Authorization Act for Fiscal Year 2010, H.R. 2647, 111th Cong. § 933 (2009) (proposing the establishment of a Department of Defense School of Nursing to help produce "military health professionals" in order to quell the civilian nurse shortage, and to encourage medics and corpsmen to obtain Bachelor of Science degrees in Nursing, perhaps even continuing on to the Department of Defense's Physician Assistant program); H.R. 6339, 111th Cong. § 2(a) (2010) (proposing a bill that would allow the Secretary of Veterans' Affairs to create a program that would provide aid to military medics and corpsmen that attempt to transition from military medicine to civilian physician assistant positions); Hiring Heroes Act of 2011, S. REP. NO. 112-36, §§ 10, 13-14 (2011) (promoting changes within the Federal Government, including the Department of Defense, Department of Labor, the Veterans Association, and the Department of Homeland Security, to allow for better transitional training and opportunities for veterans).

48. See NAT'L ECON. COUNCIL, EXEC. OFFICE OF THE PRESIDENT, THE FAST TRACK TO CIVILIAN EMPLOYMENT: STREAMLINING CREDENTIALING AND LICENSING FOR SERVICE MEMBERS, VETERANS, AND THEIR SPOUSES 5-7 (2013) [hereinafter FAST TRACK], available at http://www.whitehouse.gov/sites/default/files/docs/military_credentiaing_and_licensing_report_2-24-2013_final.pdf (discussing the plans in place as well as the ones in the future to help promote better transitions for veterans into various sectors of the workforce).

49. FAST TRACK, *supra* note 48, at 7 ("The President created the Department of Dense Military Credentialing and Licensing Task Force, charged with (1) identifying military specialties that readily transfer to high-demand jobs; (2) working with civilian credentialing and licensing associations to address gaps between military training programs and credentialing and licensing requirements; and (3) providing service members with greater

national associations, including the Physician Assistant Education Association (PAEA),⁵⁰ the American Academy of Physician Assistants,⁵¹ and the Department of Veterans Affairs (VA).⁵²

In addition to the federal government's efforts, the participation of the states is an essential component to ensure that veterans receive medical education and experience applicable in civilian care.⁵³ In the forefront of this pursuit, California has implemented programs and legislation that allow medical veterans to rely on their medical knowledge and experience and take a preliminary qualification course in order to become eligible for licensure.⁵⁴ This qualification course offers veterans an opportunity to

access to necessary certification and licensing exams.”).

50. See Jeanette Smith, *PAEA Applauds White House Initiative to Help Veterans Become Physician Assistants*, PHYSICIAN ASSISTANT EDUC. ASS'N. (October 25, 2011), <http://www.paeonline.org/index.php?ht=d/sp/i/130963/pid/130963> (statement of PAEA President Kevin Lohenry) (“The Obama Administration is right to support the professional development of our returning veterans and help them enter the Physician Assistant field. . . . [It] has capitalized on a rare win-win-win policy that gives back to veterans, creates job opportunities and helps address one of the most critical health care challenges we face.”).

51. See *White House Emphasizes PA Profession for Veterans*, AM. ACAD. PHYSICIAN ASSISTANTS (Oct. 26, 2011), http://www.aapa.org/news_and_publications/news/item.aspx?id=3079 (acknowledging the Obama Administration's effort to help more veterans transition into the field of physician assistants, and applauds the Administration for “offering those who have served on the battlefield a pathway to PA educational programs”).

52. See Wakefield, *supra* note 43 (supporting and explaining how the Obama Administration plans to increase the medical education at certain military institutions as well as fun nursing schools that choose to offer “pro-Veteran learning environments, recruit and support Veterans interested in pursuing nursing careers, and facilitate academic credit for enlisted health care training”).

53. *E.g.* FAST TRACK, *supra* note 48, at 12. Considering states are the entities that set forth the legal scopes of practice for medical professions, it only makes sense that their cooperation is essential to closing the gap between the requirements of civilian care and that which is provided by the Hospital Corps. *Id.* (explaining the Obama Administration's plan to accelerate state's licensing and opportunities for military medical personnel, including pushing states to work together with academic institutions to equivocate military and academic education, and promoting states to analyze the “gaps between military training and experience and state licensing requirements” in order to “develop bridge programs to address these gaps”).

54. CAL. CODE REGS. tit. 16, § 1418 (2013) (stating that a military applicant that have satisfied the requirements of § 2736.5 of the California Business and Professional Code, and has completed a course that provided “the knowledge and skills necessary to function in accordance with the minimum standards for competency” stated in § 1443.5 is legally considered to have completed the prerequisites for licensure). In addition to California,

surpass the extensive re-education that they are required to complete in other states, and instead qualify using their own merits from their military experience.⁵⁵ By allowing veterans to skip the further institutional education requirements, California is also combating one of the prominent contributors to the nursing shortage: the limited admittance space in nursing schools.⁵⁶

Besides providing alternate routes of licensure, California is also one of several states allowing corpsmen, medics, and military nurses to challenge the LVN license exam without first requiring additional education credits; this simple step offers a possible seamless transition for medical personnel veterans into civilian care.⁵⁷ California is also easing the process for veterans residing outside of the state by reforming its interstate licensing to

several other states have begun to offer alternative qualification routes to licensure for veterans as well. *E.g.*, LOIS KAZMIER HALSTEAD ET AL., METC BASIC MEDICAL TECHNICIAN CORPSMAN PROGRAM TO LICENSED PRACTICAL NURSE COURSE PROPOSAL 1–3 (Dec. 20, 2012), available at <http://www2.illinois.gov/veterans/SiteCollectionDocuments/METC%20Corpsman%20-%20LPN%20Approved%20Gap%20Assessment.pdf> (proposing a course that would allow medical corpsmen to obtain a practical nurse certificate, and sit for the licensure exam); Goldstein, *supra* note 6, at 254, 256–58 (explaining how New Jersey has had programs in place since the 1970s to help alleviate the problems with transitioning corpsmen from the military to civilian health care professions).

55. *See, e.g.*, CAL. BUS. & PROF. CODE § 2736.5 (West 2013) (stating that, in California, an individual may qualify for certain nursing licenses upon proof of completion of their rating qualification course as well as records of medical corps experience in the Armed Forces).

56. *E.g.*, Clair Courchane, *With Nurse Shortage Looming, America Needs Shot in the Arm*, WASH. TIMES (June 6, 2011), <http://www.washingtontimes.com/news/2011/jun/6/with-nurse-shortage-looming-america-needs-shot-in-/?page=all> (claiming that the primary bar to solving the nursing shortage is not a lack of interest in the profession, but instead the general lack of nursing school space and faculty); *cf.* Nicole Ostrow, *Nursing Shortage is Over in U.S. Until Retirement Glut Hits*, BLOOMBERG (Mar. 21, 2012 11:00 PM), <http://www.bloomberg.com/news/2012-03-21/nursing-shortage-in-u-s-is-over-temporarily-researchers-find.html> (discussing the inevitable exodus of nurses in the coming years due to a large percentage of current nurses reaching the retirement age and how this will create an even more extensive nurse shortage).

57. *See supra* note 44 and accompanying text (discussing the options for veterans to challenge the LVN examination in California); *e.g.*, Emily Vizzo, *Course Helps Corpsmen, Medics Become LVNs*, SAN DIEGO UNION-TRIB., Mar. 21, 2008, http://www.utsandiego.com/uniontrib/20080321/news_1mc21lvn.html (explaining the opportunity for medical veterans to take a course offered by MiraCosta College in order to challenge the LVN examination and become licensed in California).

permit less stringent standards for interstate LVN license transfers.⁵⁸ These steps taken by California are both basic and beneficial, which is why they should not only be recognized by other states but also replicated and implemented in order to nationalize the modernization of the transition into civilian care for veteran medical personnel.

V. PROPOSAL

In order to provide legitimate solutions to two of the most significant problems facing the United States today—the extreme shortage of nurses and general practitioners and the flood of recent veterans that are unable to find civilian employment—there must be a more dramatic dedication by both state and federal governments to provide efficient transitions for medical veterans into civilian health care. One of the most probable and efficient solutions to these problems is to follow the progressive steps of the state of California and its reformation of the transition process for these veterans.

While the federal government made efforts to improve the transition for veteran corpsmen into civilian care, the final responsibility for the process falls onto the states to make changes to help both veterans and the population as a whole. Although the current legislation in California is promising,⁵⁹ there are still an overwhelming number of states that have remained silent on the issue.⁶⁰ The statutory implementations in California

58. See CAL. BOARD OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS, APPLICATION FOR VOCATIONAL NURSE LICENSURE BY ENDORSEMENT 1 (2012), available at <http://www.bvnpt.ca.gov/pdf/endorsement.pdf> (allowing out-of-state LVNs to transfer their license to California without retaking the license exam).

59. See *supra* note 54 and accompanying text (discussing the legislation from California and New Jersey aiming to provide better transitions for veteran corpsmen).

60. *E.g.*, COMPARISONS, *supra* note 29, at 10 (recognizing that California remains an “outlier[,]” while many states have not altered their accreditation programs to accommodate military medical education and experience). However, even if it is not to the extent of California, other states have made progress in the area. See *supra* note 54 and accompanying text (discussing the historical efforts by New Jersey to ease the transitions for

provide the most prominent progress in creating change, and thus should be a template for other states to do the same. Even the most minor aspects of California's changes have made significant progress for the veteran populations in those states, and the rest of the state population benefits from the boost of medical personnel in their local hospitals due to the newly enacted laws.⁶¹

In addition to the ability to adjust licensure requirements, states also possess the power to change the legal scope of practices for medical professions.⁶² States must try to closely align the scopes of practice of the professions mentioned below with the new advanced scopes of corpsmen in order to allow a smoother transition for both sides.⁶³ On the other hand, the federal government must push the military to modernize their medical education and training programs in order to provide corpsmen the level of training that will help them succeed not only on the battlefield, but in the civilian world as well.⁶⁴ States may feel less pressure in altering their own scopes of practice for medical professionals if the various military branches can reform their own expectations and increase the scope of practice of military medical personnel to one more comparable to their civilian counterparts.

medical veterans).

61. *E.g.*, NURSING SHORTAGE, AM. ASS'N COLLS. NURSING 4–6 (2012), available at <http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf> (stating many of the benefits of adequate nursing staffing for the surrounding communities).

62. *See* REBECCA LEBUHN & DAVID A. SWANKIN, REFORMING SCOPES OF PRACTICE 2–3 (2010), available at <https://www.ncsbn.org/ReformingScopesofPractice-WhitePaper.pdf> (“It is increasingly recognized that scope of practice restrictions often prevent professionals other than physicians from practicing to the full extent of their training and skills. . . . [S]tates should be encouraged to experiment with new approaches to scope of practice as part of healthcare reform.”).

63. *Cf. id.* at 3–20 (explaining the benefits of altering the scopes of practice of certain professions in order to provide better access and care).

64. *See* Krause, *supra* note 28, at 74 (proposing the creation and implementation of a “standardized nurse transition program” throughout the navy including both clinical and non-clinical aspects, “cooperative training agreements with civilian facilities,” and establishment of more trauma and simulation centers).

Although it would be preferable for the states to act on their own in altering the scopes of practice for medical professions, if they decline to follow California's lead by altering their current laws to provide efficient transitions and opportunities to Hospital Corps veterans, federal intervention may eventually be necessary.⁶⁵ Congress must realize that the urgency of the situation may exceed deference to the states in enacting their own statutes to promote veteran transitions, and it must contemplate possible methods to accelerate the process such as providing subsidies or other benefits.⁶⁶

VI. CONCLUSION

Although the demands and change required to promote the transitions of military medical personnel to civilian practitioners appears daunting, the ultimate result is far worth the reformation and adjustment, as apparent from the positive results in California. If cooperation between the military and state legislatures can be established, the proposed changes can not only occur, but exceed expectations in solving both the problems of unemployed veterans and the nurse shortage. The PAEA's president Kevin Loheny described the situation best as a rare "win-win-win" scenario,⁶⁷ and if the correct steps are taken by the parties who hold the power to change the

65. See generally Randall R. Bovbjerg, Joshua M. Wiener, & Michael Houseman, *State and Federal Roles in Health Care*, in FEDERALISM AND HEALTH POLICY ch. 2 (John Holahn, Alan Well, & Joshua Wiener eds., Urban Institute Press 2003), available at <http://assets.wharton.upenn.edu/~housman/files/UrbanInstitute.pdf> (discussing the balance between state and federal authorities, including federal intervention, when approaching healthcare issues).

66. E.g., Health Resources & Services Administration, *Helping Veterans Become Physician Assistants*, U.S. DEP'T HEALTH & HUMAN SERVS., <http://bhpr.hrsa.gov/veterans/physicianassistants.html> (noting the \$45 million in federal grants that the Health Resources and Services Administration plan to provide for physician assistant education programs for veterans by 2016).

67. See Smith, *supra* note 50 (statement of PAEA President Kevin Loheny) (quoting Mr. Loheny in response to the Obama Administration's intentions to promote more medical veterans to pursue careers as physician assistants).

system, then there is no reason that the scenario should not end resulting as such.