NEWSLETTER
of the
American Association of Physicians' Assistants

AAPA
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DR. ESTES TALKS ABOUT THE A. A. P. A.

Recent discussions surrounding the incorporation of the Association brought out the fact that some members did not see the wisdom of a close formal relationship between the Association and an organization of physicians. The advantages of a close tie with a broadly representative group of physicians is a complex affair, but it seems to be in the best interest of the new Association, and, more important, of the new profession of Physician's Assistant.

The requirements for successful establishment of a new profession are numerous. Some are obvious - such as the need for a group of people who possess a body of knowledge and skills not possessed by the average person, and the need for a system of personal and financial rewards which make the profession attractive. Other requirements are more subtle, but equally important. There must be a *need* for the services of the new profession, and there must be a general acceptance or *trust* of the new profession.

The physician and the medical profession have a long established mandate to serve the public need in health and medical matters. This mandate has resulted in legal and political instruments, such as licenses, examining boards, accreditation of institutions, etc. Though there may have been questions as to the validity of this mandate in certain instances, it is real, and it is based on a general trust of the medical profession.

For the new profession of Physician's Assistants to become established, public acceptance of the need for the new group and a general public trust of the ability and reliability of the new group must be obtained. The need for increased availibility of medical services may be obvious to patient and physician alike, but there is still considerable disagreement as to who should meet this need - more physicians, specially trained nurses, or new professional groups such as the Physician's Assistant. The public will accept the opinion of the medical profession in these matters. If the Physician's Assistant is to be accepted by the medical profession, there must be a general trust of the new group on the part of the physician.

Trust is not generally learned; it is earned, and it is based on familiarity. We connot expect physicians to automatically accept this new group. The group must openly seek the advice and counsel of physicians, and must remain responsive to reasonable suggestions from such sources. The necessary acceptance and trust of the physician will come slowly, but it will be materially aided by the establishment of close organizational ties to a recognized group of physicians. Such an association can more widely disseminate the opinion (and hopefully the trust) of those who have worked as individuals with individuals within the new professional group.

Simply stated, public acceptance of the need for and the worthiness of the new profession will be based on the acceptance of the new profession by the physician. This will be based on the experience of individual physicians with individual Physician's Assistants, but dissemination of this experience will be markedly enhanced by close organizational ties between the two groups as well. The gains from such ties seem to far out-weigh the effort and the occasional frustration.

Dr. E. H. Estes
Chairman, Department of
Community Health Sciences

A. A. P. A. PRESIDENT SPEAKS

This issue of the Newsletter marks the beginning of our endeavors in education. It is our goal to expand the technical sections in each consecutive issue. Articles and tips are welcomed by the editorial staff.

Since Dr. Charles L. Hudson, the A.M.A. representative to the October 1968 Conference on Physicians' Assistants, rejected our petition for recognition and assistance, the Board of Directors of the A.A.P.A. has written to the President of the A.M.A. to determine exactly what must be accomplished to gain official recognition.

The Board of Directors also voted to ask certain well known physicians to serve on our advisory committee so that we can initiate work on the registration system and have assistance when confronted by problems needing professional advice.

Hopefully beginning in January the Journal Club shall expand on the following format: (1) 7:30 - 8:30 p.m. topic presentation, (2) 8:30 - 8-40 p.m. break, and (3) 8:40 - 9:30 p.m. movie of the month. The Journal Club meets

the first Tuesday of each month at 7:30 p.m. in the trailer. This is one of the tangibles we offer the membership and I hope you will take advantage of it as the speakers are excellent and Mr. R. Peterson and Mr. C. Fasser have devoted a great deal of time and energy to assure its success.

Many of the students have approached me in the past month expressing dissatisfaction with school issues, i.e., the rather large neon like patches apparently designed to warn the unwary, the G.I. Bill problem, and the rotation situation which one student likened to a musical merry-go-round with everyone grabbing for the brass ring. Some of the members have petitioned the A.A.P.A. to become involved with these and other issues. However, the Board of Directors has established the policy that the A.A.P.A. shall not interfere with nor become involved with matters at the student - administration interface. It is felt that to do so would not be in keeping with the original goals of the A.A.P.A.

Mr. C. Fasser has been elected by the Board of Directors to fill the vacancy created by Mr. V. Gemino who abdicated his position by non-payment of dues.

I am pleased to be able to extend our welcome to the students at Alderson-Broaddus College and at the University of Texas as new readers of the Newsletter. I invite your ideas and comments and hope to be able to offer you student membership in the near future.

William D. Stanhope
President A.A.P.A.

Program of the Future

THE CLINICAL ASSOCIATE

In 1966, the School of Allied Health Professions of the University of Kentucky Medical Center set in motion a pilot study in the training of men who are to be the associates of Physicians. This program required as matriculation a high school diploma; experience in the health fields; and recommended that the individuals have some college credits.

The purpose of the program is to train and equip these men with additional medical knowledge so they could take over some of the time-consuming tasks of Physicians.

This program is divided into two phases: didactic and practicum. The didactic portion consists of additional college hours of 1) English Composition, 2) Inorganic Chemistry, 3) Mathematics and 4) Anatomy and Physiology. Also, two courses are taken with the freshman medical students and two with the second year students. Successful completion of the courses does not mean this person can go on to medical school without the prescribed course of undergraduate study. The phase of study with the medical students consists of 1) 64 hours of Human Growth and Development, 2) 16 hours of Interviewing and Communication, 3) 51 hours of Epidemiology and, 4) 258 hours of Physical Diagnosis.

The second year is spent in the various clinical areas of the hospital and in the offices of the county health department under the supervision of an Internist, Generalist, and/or Surgeon. It is during this time that the associate sharpens and refines his skills.

It should be noted that this program is no longer in existence and that plans are being formalized to re-start it. The starting salary for graduates is problematical; however, it is believed to be in the neighborhood of $9,000 a year.

This program has neither the endorsement nor the approval of the AMA or of the State Medical Society.

This information was supplied by the University of Kentucky Medical Center and by Dr. Joseph Hamburg, Dean, School of Allied Health Professions.

A. A. P. A. MEMBERSHIP DUES

In the August issue of the Newsletter we printed the requirements for admission into the A.A.P.A. as an active member. The Board of Directors has made final decisions as to "active" and as to "associate" (student) membership dues.

Graduates of an approved P. A. program and who have been approved by the A.A.P.A. may be permitted active membership. One who is permitted active membership must remit a $5.00 initiation fee and a $15.00 membership fee which must be paid in $5.00 installments or more between July 1st and October 1st of any year. If remittance is not received by October 1st the potential member has a 30 day grace period which will cost that person an additional $10.00 and must be paid by November 1st.

Students of an approved P. A. program are permitted associate membership. A student must remit a $5.00 initiation fee and a $7.00 per year associate member fee. Student membership will be open from October 1st to January 1st of each year. However, this year (1969) it will remain open to March 1st, 1969. Upon graduation and upon approval by the A. A. P. A. the associate member need not pay another initiation fee but only active membership dues.

Those who wish to join the organization may send their money by check or money order to Mr. Roger Whittaker, 2222 Elba St., Durham, N. C., and should make the check payable to him. Please include a return address so that a receipt may be mailed to you.

EMPLOYMENT OFFERS

Dr. Howard, Director Duke Physicians' Assistant Program, again has given the Newsletter permission to print and make available to our membership several job offers. It must be appreciated that one should not rely on this Newsletter for all of one's job offers. Any P. A. or P. A. Trainee (well into his or her final year) who would like employment should contact Dr. Howard for specific job placement.

Here are the job offers available at the present time: (1) Dr. William Shipiro, Assistant Professor of Medicine,

Lab. For Cardio-Vascular Research, Veterans Administrations Hospital, Dallas, Texas. The P. A. would work in the cardio-vascular lab and would be responsible for operating cineangiographic equipment together with the Cordis injector. The P. A. would also operate the Electronics For Medicine Research Recorder among other instruments.

(2) Dr. Joseph L. Kahn, Diversey Clinic, 668 Diversey Parkway, Chicago, Ill. The P. A. here would be expected to work with Dr. Kahn in a busy clinic.

(3) Dr. Charles G. Young, Assistant Director Medical Division, E. I. DuPont DeNemours and Co,. Inc., Chambers Works, Deepwater, N. J. The job description for the P. A. who would work here is unknown. The P. A. might do new employee examinations along with caring for chamber accidents and injuries.

(4) Dr. Charles W. Styron, 615 St. Marys Street, Raleigh, N. C. 27605. This doctor is considering a P. A. to work in his office practice for $10,000 a year.

(5) Dr. B. J. Boss, Neurologic Associates, Neuro-Psychiatric Institute Building, Box 32, 700 First Avenue South, Fargo, North Dakota 58102. It is unknown as to what the job description will be for the P. A. eanting employment here.

It is the wish of Dr. Howard that everyone who corresponds in response to these job offers be truly interested and be absolutely positive that this is where your interest lies.

BENEFITS OF A. A. P. A. MEMBERSHIP

There are many reasons for a Physicians' Assistant to become a member of the A. A. P. A. The major advantages at the present are (1) a Journal Club which will meet on the first Tuesday of each month at 7:30 p.m. and will feature a lecture series followed by a social hour; (2) a Newsletter which is both informative and educational and will unite students and graduates as they spread throughout the country; and (3) a monthly film series soon to begin presenting only the best in medical education. There is much work being done to provide such benefits as group insurance and sponsorship by a national organization. It is also the hope that other students and graduates from approved P. A. programs will enlist in the A. A. P. A. which will increase not only the manpower of the association but its capabilities.

DUKE SCHOOL CORNER

Dr. Robert Howard, Physicians' Assistant Program Director at Duke, informs us that the class starting in September of 1969 will be composed of an enlarged student body of forty. The new class will have essentially the same didactic first year but will have a much innovated second year of rotations in either surgery, pediatrics, or medicine. After choosing his or her specialty the student may take one rotation (usually 8 weeks) in the other two specialties not chosen. So that if a student chooses a second year of mainly surgery he may take one rotation in both pediatrics and medicine. In each specialty there will be those rotations which are required and elective.

TIPS OF THE MONTH

A LESS PAINFUL WAY TO CATHETERIZE MEN WHO HAVE PROSTATIC ENLARGEMENT

Men who have urinary retention secondary to prostatic enlargement are susceptible to much pain upon catheterization. The person performing such a task may have much difficulty. If you find it difficult to catheterize such a person insert the catheter until you find resistence. Then retrieve an irrigation syringe containing sterile saline or sterile water (at room temperature). As you insert the catheter inject the water or saline into the catheter under pressure. No matter how distended the bladder, catheterization will be much easier and less painful for the person being catheterized. The procedure is even easier if you have an assistant inject the fluid while you insert the catheter. [1]

A METHOD FOR REMOVAL OF SUBUNGUAL HEMATOMA

Subungual hematoma is usually caused by trauma and can be painful and dangerous to a person's health. Optimal surgical conditions are nice to have for removal of such a hematoma or an abcess. But if such conditions do not exist evacuation of the hematoma still might be necessary. Place a piece of paper clip in a kelly clamp and heat the clip until it is white hot. Touch the hot clip to the base of the nail until it extends through the nail and to the hematoma. [2]

EDUCATIONAL ARTICLES

A POINT SCORE SYSTEM FOR THE ECG DIAGNOSIS OF LEFT VENTRICULAR HYPERTROPHY

A point score system was presented for the diagnosis of LVH by EKG. The point score system was evaluated in an autopsy series of 150 hearts and was positive 60% of the time when LVH was present at autopsy. The point score system is more sensitive in the presence of combined hypertension and coronary artery disease.

Table I reveals the point score system for the diagnosis of LVH.

TABLE I. POINT SCORE SYSTEM [3]

	Points
1. Amplitude*	3
2. ST-T Segment	
Without digitalis§	3
With digitalis	(1)
3. Left atrial involvement†	3
4. Left axis deviation‡	2
5. QRS duration⊕	1
6. Intrinsicoid deflection□	1
Maximum total	13

Five points is read as LVH

Four points is read as probable LVH

*Positive if any one of the following are present: (1) largest R or S wave in the limb leads ≧ 20mm., (2) S wave in V-1 or V-2 ≧ 30mm., (3) R wave in V-5 or V-6 ≧ 30 mm.

§Positive if typical ST-T pattern of left ventricular strain is present (ST-T segment vector shifted in direction opposite to mean QRS vector).

†Positive if the terminal negativity of the P wave in V-1 is 1mm. or more in depth with a duration of 0.04 second or more.

‡Positive is left axis deviation of -30 or more is present in frontal plane.

⊕Positive if QRS duration is ≧ 0.09 second.

□Positive if intrinsicoid deflection in V-5 or V-6 ≧ 0.05 second.

IRON DEFICIENCY ANEMIA

Anemia within itself is not a disease or a diagnosis, but rather a manifestation of some further underlying disorder or disease. In dealing with anemia, one soon recognizes that the most common type, is of an iron-lacking nature.

Iron deficiency anemia itself is probably one of the most simple entities in medicine to treat. If found, mere administration of replenishment iron theropy will reverse the anemia rapidly. This, however, will not solve the problem as to why the patient has become iron deficient. The basic disease process must be sought out and delt with, and in most instances blood loss either acute or chronic is the reason for this iron depletion. There are other reasons that could lead to this form of anemia, one is seen in infants at about age one or two years, when body growth is so rapid that iron stores are completely depleted and cannot keep up with the rapid expansion of the vascular tree; also this could be expected during adolescence again because of the rapid growth at these ages, or in closely spaced pregnancies or pregnancies producing multiple births.

Iron deficiency anemia should be thought of when, for many reasons, iron loss exceeds iron absorption and impairs hemoglobin production and depletes iron stores. Examples of this would be in any chronic blood loss usually occuring in the gastro-intestinal or genito-urinary tract or in menstruating women of child bearing age. Iron deficiency is very uncommon secondary to nutritional causes today, except in cases of clay eating such as we see occasionally here at Duke. The normal adult loses 1 mg. of iron per day and even if all dietary intake were stopped, if this were possible, it would take an adult male 6 years and a female 4 years to lower their iron stores enough to cause iron deficiency anemia. Therefore the likelihood of nutritional iron lack anemia is very minute.

The signs and symptoms of iron deficiency anemia are those common to all types of anemias and they are: pallor, easy fatigability, anorexia, weakness, lassitude, palpitations, dyspnea on exertion, angina of effort, and ankle edema. The onset is usually over a period of time and the progression slow, usually measured in many months to years. The reason for this is that the body is able to compensate for the decreased hemoglobin content, and symptoms expected in such an anemia are remarkably diminished and few. In children a craving for unnatural foods such as dirt and paint, which may suggest an underlying deficiency, is said to be completely abolished by appropriate administration of iron. Frequent complaints of brittle, thin fingernails are common in long standing iron lack, and may even exhibit actual spooning of the nails which is termed koilonychia. A smooth tongue with atrophic papillation may be seen, but more commonly seen with soreness in B_{12} deficiency or pemicious anemia. In rare cases all mucus membranes may be involved with resulting stomatitis, viginitis, proctitis, etc. Decreased menstrual flow or irregular flow in the female may also be a tip off to an otherwise asymptomatic anemia. Most often all of the previous symptoms will not be found and the single complaint of a tired, run-down feeling may be the only indication you have pointing to the anemia. Physical findings secondary to decreased hemoglobin of pallor, tachycardia and cardiomegally may be the only objective constituents. Lingual atrophy and koilonychia usually occur after long standing iron deficiency anemia.

Microcytic, hypochromic red blood cells with a low reticulocyte count are the base findings in the peripheral blood. White cells and platelets are usually normal, but may be decreased in severe anemia. Usually hct., hgh. and RBC count all will be decreased, but there may be a normal number of RBC only poorly filled with hgh., so that the crit. and RBC count could be normal, but the hemoglobin concentration markedly diminished.

Bone marrow exam shows erythroid hyperplasia with decreased cellular hemoglobin in most of the normoblasts. The only other finding in the bone marrow would be no stainable iron. This single finding more than any other will confirm the diagnosis of iron deficiency anemia.

Iron deficiency may be present without a hypochromic microcytic blood film. In cases of acute bleeding or even mild chronic bleed, iron may yet be present in great enough quantities to produce normal cells. However, when the level becomes diminished to a great enough extent the marrow will begin to try and compensate for defective hemoglobin production by releasing many small poorly filled cells and the anemia thus acquires the microcytic hypochromic characteristics. Therefore it may be stated that many people may suffer from iron deficiency without true iron deficiency anemia.

To summarize, iron lack anemia in the adult male and post menopausal female is basically caused by blood loss, and it cannot be emphasizes enough that when this type of anemia is seen, it is then up to the diagnostician, M.D., P.A. or whoever to find the source of this blood loss. Most often it is in the gastro-intestinal or genito-urinary tract, but all areas must be ruled out as possible

sites. All to often it is caused by a malignant growth, and this anemia may be an important sign in enabling the clinician to find this malignancy and ultimately arrest it in the appropriate manner if possible.

As stated previously to treat the anemia itself the appropriate and the only therapy needed is replenishment of iron. In true iron deficiency when iron is administered there is a brisk reticulocytosis with an initial increase in number of cells and shortly thereafter a rise in hemoglobin content. In a matter of days there will be few microcytic hypochromic cells seen on peripheral film. The picture will continue to improve until normal, unless the bleeding site is not found in which case the anemia will return.

There are other anemias similar in appearance on film to iron deficiency. Some of these are: 1) Cooley's Thalassemia 2) Rheumatoid arthritis 3) chronic infection 4) chronic renal failure 5) Phridoxine deficiency - B_6. These however, will present different clinically from true iron deficiency on the basis of history, differential diagnosis and most importantly on their non-response to iron therapy.

EDITORIAL

COMMUNICATION - A MUST

If one were to be associated with an institution of higher learning or a professional organization and if one were to look at the modern and rapid modes of communication, one would think that sending and receiving information would be no problem. This is not always the case and the causes seem to me to be a very obvious few. People who do not have the mental ability to make sound early decisions are greatly at fault. An administration which lacks in coordination of its personnel is at fault. Proper modes of communication should be utilized and the correct address should always be known. Communication is the backbone of every organization and I believe we need to be more proficient in this area. Let us not criticize our delivery systems but question those in leadership!

NOTES

The Newsletter staff (total of one) welcomes the addition of Mr. R. Cox, Mr. E. Eason, and Mr. C. Fasser to its staff - Are medical students who wear lab coats and name tags with a medicine imprint, Doctors? - Such a big noise over nothing from both sides - And I'm proud to be a P.A. to - Congratulations to the University of Colorada Pediatric Associates Program for they just received $450,000 from the Carnegie Corporation and the Commonwealth Fund to certify associates to diagnose, treat ailments, and write certain prescriptions according to Mr. Thomas Brady of the New York Times paper - P.S. They also got a shot of $73,179 from the Bureau of Health Manpower - Hello to the students at Alderson - Broaddus College and the University of Texas - Next issue, an editorial on the Ideal Physician's Assistant Program - if there is such a thing.

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