American Medical Association
Council on Medical Education
Advisory Committee on Education for the
Allied Health Professions & Services

2nd Draft - 8/9/71

Minutes of the Meeting

of the

SUBCOMMITTEE TO DRAFT ESSENTIALS OF AN APPROVED EDUCATIONAL PROGRAM FOR PHYSICIAN'S ASSISTANTS

Tuesday & Wednesday, August 3-4, 1971
Marriott Motor Hotel, Chicago

Presiding: Richard O. Cannon, II, M.D., Chairman

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Edward J. Kowalewski, Jr., M.D.
Mr. Charles E. Nyberg

AMERICAN ACADEMY OF PEDIATRICS

J. Rhodes Haverty, M.D.

AMERICAN COLLEGE OF PHYSICIANS

Malcolm L. Peterson, M.D.

AMERICAN SOCIETY OF INTERNAL MEDICINE

James E. Collins, M.D.
Frank A. Riddick, M.D.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. H. Robert Cathcart
Mr. Joseph Keyes
Eugene V. Stead, M.D.

AMERICAN MEDICAL ASSOCIATION

Richard O. Cannon, II, M.D., Chairman
Mrs. Lucie Young, RN, Ph.D., (Consultant, AMA Committee on Nursing)

PHYSICIAN EDUCATORS

Col. George R. Anderson, USAF, MC
Department of Defense
D. Robert Howard, M.D.
Duke University
Hu C. Myers, M.D.
Alderson-Broaddus College
Evan Otteson, M.D.
MEDEX
Leland E. Powers, M.D.
Bowman Gray School of Medicine
Albert M. Sadler, Jr., M.D.
Yale University School of Medicine
Richard A. Smith, M.D.
MEDEX

AMA STAFF

Warren G. Ball, D.D.S.
Miss Joyce Burger
John J. Fauser, Ph.D.
Miss Charlotte Johnson
Ralph C. Kuhli, M.P.H., Secretary
Miss Christine Orzel
C. H. William Ruhe, M.D.
T. F. Zimmerman, Ph.D.

First Session; Tuesday, August 3

In convening the dinner meeting at approximately 7:00 pm, Dr. Cannon recalled that the Subcommittee had agreed that a Task Force on Curriculum should meet to draft appropriate wording for that section of the proposed *Essentials*. The Task Force had met that afternoon and Dr. Cannon asked Dr. Howard to present the resulting draft to the full Subcommittee.

Dr. Howard reported that the physician-educators began their work by mail and conferences, using comments gathered previously by additional experienced directors of educational programs for physician's assistants. In attempting to draft the section on 'Curriculum', it had become apparent that sections previously accepted by the full Subcommittee would have to be rewritten to assure consistency. The Task Force on Curriculum believed a revision of the total document, utilizing the standard format provided by the Council on Medical Education, was necessary.

The results of this correspondence and these conferences were brought to the Task Force on Curriculum, which met that afternoon from 1:30 to 5:30 pm and drafted a revised version of the proposed *Essentials*. This revision was typed and distributed during dinner, and Dr. Cannon had copies distributed to the full subcommittee.

Dr. Cannon suggested that the meeting recess to allow the subcommittee members time to review the document. Members were asked to reassemble the following day. The first session recessed at approximately 8:30 pm Tuesday.

Second Session; Wednesday, August 4

Dr. Cannon reconvened the Subcommittee meeting at 8:30 am. The Subcommittee adopted the following agenda:

1) Consideration of the minutes of the first meeting, May 21, 1971.
2) Clarification of the relationship of "guidelines" to the *Essentials*, and explanation of the intent and use of guidelines.
3) Agreement on the proposed *Essentials*.
4) Consideration of the relationship of *Essentials* to any national certification of physician's assistants.
5) Discussion of how endorsement of the proposed *Essentials* by the sponsoring medical organizations could be expedited.

MINUTES

The participants recognized that portions of the minutes of the May 21 meeting of the Subcommittee would be considered in depth during discussion of the Task Force's proposed revision. They agreed that the minutes accurately reflected discussions at the first meeting; they were accepted as written.

ESSENTIALS

Dr. Cannon noted that the revision presented by the Task Force included emendations of the total document, and suggested a section by section review.

The Task Force suggested that the title of the proposal be amended to *Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician*. The participants agreed that this title most accurately described the type of occupation under consideration, and was less open to misinterpretation than some terms commonly used. It was understood that acceptance of this title would not prohibit existing programs from continued use of terminology which they considered suitable for their programs. The Subcommittee agreed to amend the title.

Dr. Haverty requested, and the Subcommittee concurred, that the American Academy of Pediatrics should be included as a collaborating organization, contingent upon formal decision by their appropriate governing body.

GUIDELINES

At Dr. Cannon's suggestion, Dr. Ruhe and Mr. Kuhli clarified the basic intent of "guidelines" as supplementary material to *Essentials*: the *Essentials* are the basic minimum requirements "essential" for program approval (accreditation), while the "guidelines" generally include concrete suggestions and explanations of how a program can best meet the requirements. Dr. Ruhe added that the present tendency in drafting *Essentials* was to include only those requirements absolutely necessary to assure the basic quality of an educational program, covering other matters as suggestions or recommendations in "guidelines".

Normally, these Guidelines are written by the review committee charged with the actual review and evaluation of educational programs by the sponsoring organizations. The Guidelines are presented to the Council on Medical Education for acceptance. Guidelines do not require formal adoption by either the sponsoring organizations or the AMA House of Delegates. Dr. Ruhe added that an interim body or committee could be designated to draft such guidelines for educational programs for the assistant to the primary care physician, which could then be submitted to a Joint Review Committee when it is appointed by the sponsoring organizations.

ACTION: The Subcommittee agreed upon the urgent need to develop Guidelines to supplement and complement the "Essentials", and further recommended that a continuing activity of the Subcommittee be the development of those Guidelines.

Some concern over the size of the Subcommittee was expressed. Dr. Cannon pointed out that the same procedure used in drafting the section on Curriculum in the proposed *Essentials* could be followed: a Task Force could draft Guidelines and present their proposal to the full Subcommittee for discussion and consideration.

The Subcommittee then reviewed the proposed *Essentials*. The document, as revised and approved, follows.

ESSENTIALS OF AN APPROVED EDUCATIONAL PROGRAM FOR THE ASSISTANT TO THE PRIMARY CARE PHYSICIAN*

Established by

AMERICAN MEDICAL ASSOCIATION
COUNCIL ON MEDICAL EDUCATION

in collaboration with

AMERICAN ACADEMY OF FAMILY PHYSICIANS
AMERICAN ACADEMY OF PEDIATRICS
AMERICAN COLLEGE OF PHYSICIANS
AMERICAN SOCIETY OF INTERNAL MEDICINE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Adopted by the AMA House of Delegates

____
(date)

1 OBJECTIVE
2
3 The education and health professions cooperate in this program to establish and
4 maintain standards of appropriate quality for educational programs for the
5 assistant to the primary care physician, and to provide recognition for
6 educational programs which meet or exceed the minimal standards outlined in
7 these Essentials.
8
9 These standards are to be used as a guide for the development and self-evalua-
10 tion of programs for the assistant to the primary care physician. Lists of
11 these approved programs are published for the information of employers and the
12 public. Students enrolled in the programs are taught to work with and under the
13 direction of physicians in providing health care services to patients.
14
15 DESCRIPTION OF THE OCCUPATION
16
17 The assistant to the primary care physician is a skilled person, qualified
18 by academic and clinical training to provide patient services under the super-
19 vision and responsibility of a doctor of medicine or osteopathy who is, in
20 turn, responsible for the performance of that assistant. The assistant may be
21 involved with the patients of the physician in any medical setting for which
22 the physician is responsible.

* "Assistant to the Primary Care Physician" is a generic term.

The function of the assistant to the primary care physician is to perform, under the responsibility and supervision of the physician, ~~selected~~ diagnostic and therapeutic tasks in order to allow the physician to extend his services through the more effective use of his knowledge, skills, and abilities.

In rendering services to his patients, the primary care physician is traditionally involved in a variety of activities. Some of these activities, including the application of his knowledge toward a logical and systematic evaluation of the patient's problems and planning a program of management and therapy appropriate to the patient, can only be performed by the physician. The assistant to the primary care physician will not supplant the doctor in the sphere of the decision-making required to establish a diagnosis and plan therapy, but will assist in gathering the data necessary to reach decisions and in implementing the therepeutic plan for the patient.

Intelligence, the ability to relate to people, a capacity for calm and reasoned judgment in meeting emergencies, and an orientation toward service are qualities essential for the assistant to the primary care physician. As a professional, he must maintain a respect for the person and privacy of the patient.

The tasks performed by the assistant will include transmission and execution of physician's orders, performance of patient care tasks, and performance of diagnostic and therapuetic procedures as may be delegated by the physician.

Since the function of the primary care physician is interdisciplinary in nature, involving the five major clinical disciplines (medicine, surgery, pediatrics, psychiatry, and obstetrics) within the limitations and capabilities of the particular practice in consideration, the assistant to the primary care physician should be involved in assisting the physician provide those comprehensive health care services necessary for the total health care of the patient.

The ultimate role of the assistant to the primary care physician cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility an assistant to the primary care physician may assume requires that, at the conclusion of his formal education, he possess the knowledge, skills, and abilities necessary to provide those services appropriate to the primary care setting. These services would include, but need not be limited to, the following:

1) The initial approach to a patient of any age group in any setting to elicit a detailed and accurate history, perform an appropriate physical examination, and record and present pertinent data in a manner meaningful to the physician;

2) Performance and/or assistance in performance of routine laboratory and related studies as appropriate for a specific practice setting, such as the drawing of blood samples, performance of urinalyses, and the taking of electrocardiographic tracings;

3) Performance of such routine therapeutic procedures as injections, immunizations, and the suturing and care of wounds;

4) Instruction and counseling of patients regarding physical and mental health, such as diets, disease, therapy, and normal growth and development.

5) Assisting the physician in the hospital setting by making patient rounds, recording patient progress notes, accurately and appropriately transcribing and/or executing standing orders and other specific orders at the direction of the supervising physician, and compiling and recording detailed narrative case summaries;

6) Providing assistance in the delivery of services to patients requiring continuing care (home, nursing home, extended care facilities, etc.) including the review and monitoring of treatment and therapy plans;

7) Independent performance of evaluation and treatment procedures essential to provide an appropriate response to life-threatening, emergency situations; and

8) Facilitation of the physician's referral of appropriate patients by maintenance of an awareness of the community's various health facilities, agencies, and resources.

ESSENTIAL REQUIREMENTS

I. EDUCATIONAL PROGRAMS MAY BE ESTABLISHED IN

A. Medical schools

B. Senior colleges and universities in affiliation with an accredited teaching hospital.

C. Medical educational facilities of the federal government.

D. Other institutions, with clinical facilities, which are acceptable to the Council on Medical Education of the American Medical Association.

The institution should be accredited or otherwise acceptable to the Council on Medical Education. Senior colleges and universities must have the necessary clinical affiliations.

II. CLINICAL AFFILIATIONS

A. The clinical phase of the educational program must be conducted in a clinical setting and under competent clinical direction.

B. In programs where the academic instruction and clinical teaching are not provided in the same institution, accreditation shall be given to the institution responsible for the academic preparation (student selection, curriculum, academic credit, etc.) and the educational administrators shall be responsible for assuring that the activities assigned to students in the clinical setting are, in fact, educational.

C. In the clinical teaching environment, an appropriate ratio of students to physicians shall be maintained.

III. FACILITIES

A. Adequate classrooms, laboratories, and administrative offices should be provided.

B. Appropriate modern equipment and supplies for directed experience should be available in sufficient quantities.

C. A library should be readily accessible and should contain an adequate supply of up-to-date ~~and~~ scientific books, periodicals, and other reference materials related to the curriculum.

IV. FINANCES

A. Financial resources for continued operation of the educational program shall be assured for each class of students enrolled.

B. The instution shall not charge excessive student fees.

C. Advertising must be appropriate to an educational institution.

D. The program shall not substitute students for paid personnel to conduct the work of the clinical facility.

V. FACULTY

A. Program Director

1. The program director should meet the requirements specified by the institution providing the didactic portion of the educational program.

2. The program director should be responsible for the organization, administration, periodic review, continued development, and general effectiveness of the program.

B. Medical Director

1. The medical director should provide competent medical direction for the clinical instruction and for clinical relationships with other educational programs. He should have the understanding and support of practicing physicians.

2. The medical director should be a physician experienced in the delivery of the type of health care services for which the student is being trained.

3. The medical director may also be the program director.

C. Change of Director

If the program director or medical director is changed, immediate notification should be sent to the AMA Department of Allied Medical Professions and Services. The curriculum vitae of the new director,

giving details of his training, education, and experience, must be submitted.

D. Instructional Staff

1. The faculty must be qualified, through academic preparation and experience, to teach the subjects assigned.

2. The faculty for the clinical portion of the educational program must include physicians who are involved in the provision of patient care services. Because of the unique characteristics of the assistant to the primary care physician, it is necessary that the preponderance of clinical teaching be conducted by practicing physicians.

E. Advisory Committee

An Advisory Committee should be appointed to assist the director in continuing program development and evaluation, in faculty coordination, and in coordination of effective clinical relationships. For maximum effectiveness, an Advisory Committee should include representation of the primary institution involved, the program administration, organized medicine, the practicing physician, and others.

VI. STUDENTS

A. Selection

1. Selection of students should be made by an admissions committee in cooperation with those responsible for the educational program. Admissions data should be on file at all times in the institution responsible for the administration of the program.

2. Selection procedures must include an analysis of previous performance and experience and may seek to accomodate candidates with a health related background and give due credit for the knowledge, skills, and abilities they possess.

B. Health

Applicants shall be required to submit evidence of good health. When students are learning in a clinical setting or a hospital, the hospital or clinical setting should provide them with the protection of the same physical examinations and immunizations as are provided to hospital employees working in the same clinical setting.

C. Number

The number of students enrolled in each class should be commensurate with the most effective learning and teaching practices and should also be consistent with acceptable student-teacher ratios.

D. Counseling

A student guidance and placement service should be available.

E. Student Identification

Students enrolled in the educational program must be clearly identified to distinguish them from physicians, medical students, other health professionals and students.

VII. RECORDS

Satisfactory records should be provided for all work accomplished by the student while enrolled in the program. Annual reports of the operation of the program should be prepared and available for review.

A. Student

1. Transcripts of high school and any college credits and other credentials must be on file.

2. Reports of medical examination upon admission and records of any subsequent illness should be retained.

3. Records of class and laboratory participation and academic and clinical achievements of each student should be maintained in accordance with the requirements of the institution.

B. Curriculum

1. A synopsis of the current curriculum should be kept on file.

2. This synopsis should include the rotation of assignments, the outline of the instruction supplied, and lists of multi-media instructional aids used to augment the experience of the student.

C. Activity

1. A satisfactory record system shall be provided for all student performance.

2. Practical and written examinations should be continually evaluated.

VII. CURRICULUM

A. The length of the educational programs for the assistant to the primary care physician may vary from program to program. The length of time an individual spends in the training program may vary on the basis of the student's background and in consideration of his previous education, experience, knowledge, skills and abilities, and his ability to perform the tasks, functions, and duties implied in the "Description of the Occupation".

B. Instruction, tailored to meet the student's needs, should follow a planned outline including:

1. Assignment of appropriate instructional materials.

2. Classroom presentations, discussions, and demonstrations.

3. Supervised practice discussions.

4. Examinations, tests, and quizzes - both practical and written - for the didactic and clinical portions of the educational program.

C. General courses or topics of study, both didactic and clinical, should include the following:

1. The general courses and topics of study must be achievement oriented and provide the graduates with the necessary knowledge, skills, and abilities to accurately and reliably perform the tasks, functions, and duties implied in the "Description of the Occupation".

2. Instruction should be sufficiently comprehensive so as to provide the graduate with an understanding of mental and physical disease in both the ambulatory and hospitalized patient. Attention should also be given to preventive medicine and public health and to the social and economic aspects of the systems for delivering health and medical services. Instruction should stress the role of the assistant to the primary care physician relative to the health maintenance and medical care of his supervising physician's patients. Throughout, the student should be encouraged to develop those basic intellectual, ethical, and moral attitudes and principles that are essential for his gaining and maintaining the trust of those with whom he works and the support of the community in which he lives.

3. A "model unit of primary medical care", such as the models used in departments of family practice in medical schools and family practice residencies, should be encouraged so that the medical student, the resident, and the assistant to the primary care physician can jointly share the educational experience in an atmosphere that reflects and encourages the actual practice of primary medical care.

4. The curriculum should be broad enough to provide the assistant to the primary care physician with the technical capabilities, behavioral characteristics, and judgement necessary to perform in a professional capacity all of his assignments, and should take into consideration any proficiency and knowledge obtained elsewhere and demonstrated prior to completion of the program.

IX. ADMINISTRATION

A. An official publication, including a description of the program, should be available. It should include information regarding the organization of the program, a brief description of required courses, names and

academic rank of faculty, entrance requirements, tuition and fees, and information concerning hospitals and facilities used for training.

B. The evaluation (including survey team visits) of a program of study must be initiated by the express invitation of the chief administrator of the institution or his officially designated representative.

C. The program may withdraw its request for initial approval at any time (even after evaluation) prior to final action. The AMA Council on Medical Education and the collaborating organizations may withdraw approval whenever:

1. The educational program is not maintained in accordance with the standards outlined above, or

2. There are no students in the program for two consecutive years.

Approval is withdrawn only after advance notice has been given to the director of the program that such action is contemplated, and the reasons therefor, sufficient to permit timely response and use of the established procedure for appeal and review.

D. Evaluation

1. The head of the institution being evaluated is given an opportunity to become acquainted with the factual part of the report prepared by the visiting survey team, and to comment on its accuracy before final action is taken.

2. At the request of the head of the institution, a reevaluation may be made. Adverse decisions may be appealed in writing to the Council on Medical Education of the American Medical Association.

E. Reports

An annual report should be made to the AMA Council on Medical Education and the collaborating organizations. A report form is provided and should be completed, signed by the program director, and returned promptly.

F. Reevaluation

The American Medical Association and collaborating organizations will periodically reevaluate and provide consultation to educational programs.

X. CHANGES IN ESSENTIALS

Proposed changes in the *Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician* will be considered by a standing committee representing the spectrum of approved programs for the assistant to the primary care physician, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, the American Society of Internal Medicine, and the Association of American Medical Colleges. Recommended changes will be submitted to these collaborating organizations and the American Medical Association.

XI. APPLICATIONS AND INQUIRIES

A. Application for program approval should be directed to:

Department of Allied Medical Professions and Services
Division of Medical Education
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

B. Inquiries regarding career information should be addressed to:

Department of Allied Medical Professions and Services
Division of Medical Education
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

or any approved program.

C. Inquiries regarding registration or certification of qualified graduates of the approved programs should be addressed to:

Department of Allied Medical Professions and Services
Division of Medical Education
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

ACTION: *The Subcommittee agreed upon the preceding draft of "Essentials for an Approved Educational Program for the Assistant to the Primary Care Physician".*

The Subcommittee requested that representatives of the collaborating medical organizations report this draft to their officers and executive staff. Prompt consideration and endorsement was recommended by the Subcommittee.

CERTIFICATION

The subcommittee had discussed the importance of some type of certification of assistants to the primary care physician at its May 21, 1971 meeting. Dr. Cannon reiterated the importance of this activity.

In 1967, the AMA Council on Medical Education charged its Advisory Committee on Education for the Allied Health Professions and Services:

> "To keep abreast of licensure, certification, and registration of allied personnel in the United States and how such regulations may affect availability and training of allied health personnel."

Dr. Cannon suggested that the Subcommittee consider giving its support to the development of an appropriate mechanism and procedure, within the American Medical Association, for certification of assistants to the primary care physician.

Dr. Ruhe reported that the American Medical Association is currently on record as favoring national certification for assistants to the primary care physician, and that the AMA Council on Health Manpower was currently considering recommending that an examination of assistants to the primary care physician be required.

ACTION: *The Subcommittee agreed to support AMA efforts towards development, in collaboration with other appropriate medical organizations, of national certification for assistants to the primary care physician.*

ENDORSEMENT OF ESSENTIALS

The Subcommittee then discussed the "timetable" for consideration of the proposed *Essentials*. Dr. Riddick reported that the proposal could be considered by the American Society of Internal Medicine in early October. Dr. Kowalewski reported that action could be taken by the American Academy of Family Physicians in September. Dr. Peterson reported that the American College of Physicians could consider the draft in November. Dr. Haverty reported that the proposal could be considered by the American Academy of Pediatrics in September or October. Mr. Keyes reported that the Association of American Medical Colleges might be able to act on the proposal in mid-August.

To allow consideration by the AMA House of Delegates during its next session, November 29 through December 1, AMA procedures would normally require that the proposed *Essentials* be submitted in mid-October for inclusion in the House of

Delegates Handbook. If this was not possible, Dr. Ruhe suggested that the draft might conceivably be sent to members of the House of Delegates as supplementary material to the handbook. This would still allow members of the House sufficient time to study and review the draft before the clinical session in New Orleans.

ACTION: The subcommittee representatives of the collaborating medical organizations agreed to attempt to expedite consideration of the proposed Essentials to allow consideration by the AMA House of Delegates in December.

CONCLUDING REMARKS

The members of the Subcommittee recognized the profusion of legislative activity relating to assistants to the primary care physician and including recognition of educational programs and certification of such assistants. Dr. Stead suggested, and members of the Subcommittee agreed, that the proposed *Essentials* be made available to the individuals involved in these activities and to other educational programs for assistants to the primary care physicians not represented on the Subcommittee. It was agreed that the proposal could be distributed as a draft, with the concurrence of the members of the Subcommittee but without the formal endorsements of the sponsoring medical organizations.

Mrs. Young suggested that those programs not offering academic credit be urged to do so. She further reported that, on the basis of the proposed *Essentials*, utilization of nurses as assistants to primary care physicians would be an extension rather than an expansion of their current role.

Dr. Cannon thanked the participants and adjourned the meeting at approximately 2:15 pm.