AMERICAN MEDICAL ASSOCIATION
Council on Medical Education
Advisory Committee on Education for the
Allied Health Professions & Services

Meeting of the

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

[NOTE: Primary Physician's Assistant (Generalist)]

8:30 am, Friday, May 21, 1971
The Ambassador West Hotel; Sarah Siddons Suite
Chicago, Illinois

Presiding: Richard O. Cannon, II, M.D.
Member, Advisory Committee

PROPOSED AGENDA

I. PARTICIPANTS

List and mailing addresses

2. FACT SHEET

Description of existing collaborative relationships between the AMA Council on Medical Education and other medical specialty and allied health organizations for the accreditation of educational programs.

3. DEVELOPMENT OF ESSENTIALS

Statement on the procedure used to develop minimal educational requirements (*Essentials*) for an allied health occupation. (This is page 295 of the 1971 issue of the AMA's *Directory of Approved Allied Medical Educational Programs*.)

4. STANDARD FORMAT

The Council on Medical Education's format for the development of Essentials for an allied health occupation.

(more)

5. DESCRIPTION OF THE OCCUPATION

List of specific tasks rather than general comments on the field. The April 13th revision of the medical specialty societies' Task Force report, "The Physician's Assistant", provides three lists from which a selection can be made:

A. A brief outline on page 2,

B. A paragraph on each major element of patient care on pages 3 and 4, and

C. A detailed list on pages 9, 10, and 11.

6. ESSENTIAL REQUIREMENTS

Proficiency to perform the tasks listed above is the objective. What kinds of programs prepare students to perform these tasks? The *Essentials* may outline several acceptable channels of education and experience; for example:

A. Military and civilian education and experience in medical service may qualify students for admission to a program which may be

(1) Three months of college plus 15 months of clinically supervised training, or

(2) An additional two years of higher education, including clinical education.

B. Four years of higher education, culminating in a baccalaureate degree.

C. Other

NOTE: The objective is to assure that the student has learned what is necessary to perform the tasks outlined for the primary Physician's Assistant (generalist).

7. ADOPTION OF ESSENTIALS

Description of the process used to adopt *Essentials* by the collaborating organizations and the American Medical Association.

List of Participants (as of 5/17/71)

TASK FORCE TO DRAFT ESSENTIALS
OF AN APPROVED EDUCATIONAL PROGRAM FOR PHYSICIAN'S ASSISTANT

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AMERICAN MEDICAL ASSOCIATION

(Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services)

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AMA STAFF

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John J. Fauser, Ph.D.
Miss Joyce Burger

(as of 5/17/71)

TASK FORCE TO DRAFT ESSENTIALS
OF AN APPROVED EDUCATIONAL PROGRAM FOR PHYSICIAN'S ASSISTANT

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COUNCIL ON
MEDICAL EDUCATION

ALLIED MEDICAL EDUCATION FACT SHEET

1. ORGANIZATIONS. The Council on Medical Education of the American Medical Association collaborates with:

American Academy of Orthopaedic Surgeons
American Association of Inhalation Therapy
American Association of Medical Assistants
American College of Chest Physicians
American College of Radiology
American Medical Record Association
American Occupational Therapy Association
American Physical Therapy Association
American Society of Anesthesiologists
American Society of Clinical Pathologists
American Society of Medical Technologists
American Society of Radiologic Technologists
Society of Nuclear Medical Technologists
Society of Nuclear Medicine

The Council on Medical Education has an Advisory Committee on Education for the Allied Health Professions and Services, with a Panel of Consultants composed of one representative of each of the collaborating organizations. The Panel provides the Advisory Committee and the Council with a broad base of information and a two-way channel of communication.

2. OCCUPATIONS. The organizations listed above collaborate in providing services for educational programs for the following allied medical occupations:

Certified Laboratory Assistant
Cytotechnologist
Histologic Technician
Medical Assistant
Medical Record Librarian
Medical Record Technician
Medical Technologist
Nuclear Medicine Technician
Nuclear Medicine Technologist
Occupational Therapist
Orthopaedic Physician's Assistant
Physical Therapist
Radiation Therapy Technologist
Radiologic Technologist

In addition, "Essentials" are being drafted for the Urologic Physician's Assistant, Blood Bank Specialist, Medical Laboratory Technician, and several other occupations.

DEVELOPMENT OF ESSENTIALS

The development of *Essentials* for an allied medical educational program involves the cooperation of national professional associations interested in the education and employment of the allied health worker. These organizations should strive to identify and define the relationship of the allied occupation to the patient's needs. The following questions should be answered.

1. What services are needed by the patient?
2. How can these services be provided most effectively?
3. Can the people in existing health occupations provide these services most efficiently?
4. If not, what new allied health occupation is needed?
5. What, exactly, are the tasks which this new allied health occupation will be expected to perform?
6. What educational program is needed to develop the proficiency necessary to perform these tasks?

The American Medical Association asks that interested national organizations take the first five steps in cooperation with the American Medical Association Council on Health Manpower, using the AMA "Guidelines for Development of New Health Occupations." If and when it has been determined that a new allied health occupation is a necessary member of the health care team, the Council on Health Manpower formally recognizes the occupation and refers it to the Council on Medical Education.

The AMA Council on Medical Education continues the work by encouraging the development of an outline of minimal requirements for AMA approval of the educational program. Usually the national professional associations representing the medical specialty, the allied health profession, and the national professional education organizations concerned work together to agree on the essential elements of the educational program. In some cases; the Council on Medical Education may invite the various medical specialty, allied health, and education organizations specifically concerned to send representatives to meetings called for the purpose of drafting *Essentials*.

The Council of Medical Education has approved a standard format as a guide for drafting *Essentials* of an acceptable educational program. (See the following pages.)

When the organizations concerned have decided what should be included in the minimum requirements for AMA approval, they formally transmit the agreed upon draft for the *Essentials* to the AMA. This is usually done by a letter of transmittal from the President of each medical specialty and allied health organization to the AMA Council on Medical Education through it Advisory Committee on Education for the Allied Health Professions and Services.

After review by the Advisory Committee on Education for the Allied Health Professions and Services and the Council on Medical Education, the *Essentials* are included in the Council on Medical Education report to the AMA House of Delegates, which adopts the *Essentials*. The *Essentials* are used as a guide by those who are developing educational programs for the allied health occupation and seek AMA approval, and serve as a check-list for self-evaluation and for site visits by survey teams.

The *Essentials* encourage sound educational experimentation and innovation: the various review committees are receptive to proposals for new and better minimal standards. Furthermore, the *Essentials* can be revised readily, because the AMA House of Delegates meets every six months.

Thus the standards for educational programs for allied medical occupations are set by the national organizations most directly concerned: the allied health organizations involved, possibly medical specialty organizations, organizations representing higher education and the American Medical Association.

AMERICAN MEDICAL ASSOCIATION
COUNCIL ON MEDICAL EDUCATION

STANDARD FORMAT

ESSENTIALS OF AN APPROVED EDUCATIONAL PROGRAM FOR _____

(name of allied health occupation, plural)

_____

(name of allied health occupation, plural)

Adopted / Revised by the AMA House of Delegates

_____

(date)

. . .Established by. . .

AMERICAN MEDICAL ASSOCIATION
COUNCIL ON MEDICAL EDUCATION
in collaboration with

_____

(names of collaborating organizations, all in capitals)

OBJECTIVE: The education and health professions cooperate in this program to establish and maintain standards of appropriate quality for educational programs in the allied health professions and services, and to provide recognition for educational programs which meet or exceed the minimal standards outlined in these *Essentials*.

These standards are to be used as a guide for the development and self-evaluation of allied health educational programs. Survey teams report on site visits, and lists of the accredited programs are published for the information of employers and the public. Students for the allied health occupations are taught to work with and under the direction of physicians in providing health care services to patients.

DESCRIPTION OF THE OCCUPATION

(List of specific tasks rather than general comments on the field.)

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ESSENTIAL REQUIREMENTS

I. EDUCATIONAL PROGRAMS MAY BE ESTABLISHED IN:

A. Junior Colleges, Senior Colleges and Universities
B. Hospitals and Clinics
C. Laboratories
D. Medical Schools
E. Vocational/Technical Schools and Institutions

The institution should be accredited or otherwise acceptable to the Council on Medical Education of the American Medical Association. Schools, 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 academic training and clinical experience are not provided in the same institution, accreditation shall be given to the institution responsible for the academic training/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 effective ratio of students to instructors shall be maintained.

III. FACILITIES:

A. General - Adequate classrooms, laboratories, and administrative offices should be provided.
B. Laboratory - Appropriate modern equipment and supplies for directed experience should be available in sufficient quantities for student participation.
C. Library - 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 through regular budgets.

B. The institution 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:

The instructional staff should be qualified, through academic preparation and experience, to teach the subjects assigned. A planned program for their continuing education should be provided.

A. Director of Educational Program

1. Qualifications- _____

_____

_____

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2. Responsibilities-In addition to other assigned responsibilities the director of the educational program should be responsible for the organization, administration, periodic review, continued development, and general effectiveness of the program.

B. Medical Director

The medical director of the program should provide competent medical direction for the clinical instruction and for clinical relationships with other allied health educational programs and should develop the understanding and support of practicing physicians.

C. Change of Director

If the Director of Educational Program or the Medical Director of a program 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 the details of his training, education, and experience in the field, must be submitted, and, if the new director's credentials are in order, accreditation of the program will be continued.

D. Instructional Staff

The faculty should be qualified, through academic preparation and experience, to teach the subjects assigned. A planned program for their continuing education should be provided.

E. Advisory Committee

An advisory committee should be appointed to assist the directors in continuing program development and evaluation, in faculty coordination, and in coordinating effective clinical relationships.

VI. STUDENTS

A. Selection - In colleges and universities, selection of students should be made in accordance with the generally accepted practice of the institution. In hospital-sponsored programs, 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 colleges, universities, or hospitals sponsoring the program.

B. Health - Applicants shall be required to submit evidence of good health and successful vaccination. A student health service should be available for evaluation and maintenance of the students' health. When students are learning in a clinical setting or a hospital, the hospital or clinical setting should provide such students 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.

VII. RECORDS

Satisfactory records should be provided for all work accomplished by the student in the training program. Monthly and annual reports of the work of the department should be prepared and available for review.

A. Student

1. Transcripts of high school and any college credits and other credentials must be available.
2. Report of medical examination upon admission and record of any subsequent illness should be retained. A report of medical examination, including a chest film, should be kept on record.
3. A record of class and laboratory participation and accomplishment of each student should be maintained in accordance with the requirements of the institution.
4. Attendance and grades must be suitably recorded.

B. Curriculum

1. A copy of the complete curriculum should be kept on file.
2. Copies of course outlines, class schedules, directed experience, schedules, and teaching plans should be on file and available for review.

C. Activity

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

2. Copies of practical and written examinations should be maintained and continually evaluated.

VIII. CURRICULUM

A. The minimal length of the educational program should total _____ *mos. or yrs.* nothing

B. Instruction should follow a planned outline which includes:
   1. Assignment of appropriate instructional materials.
   2. Classroom presentations, discussions, and demonstrations.
   3. Supervised practice discussions.
   4. Examinations, tests, and quizzes - both oral and written - for didactic and clinical aspects of the program.

C. General courses or topics of study, both didactic and clinical.
   (NOTE: Specific suggestions may be made available in "guidelines" which supplement these Essentials.)

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D. A synopsis of the complete curriculum should be kept on file. This instructional program 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.

IX. ADMINISTRATION

A. Catalog - An official publication including a description of the curriculum should be issued at least biennially. 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 directed experience.

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

C. Withdrawal - The institution may withdraw its request for initial accreditation at any time (even after evaluation) prior to final action. The AMA Council on Medical Education and collaborating organizations may withdraw accreditation 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.

   Accreditation is revoked only after advance notice has been given to the head of the institution that such action is contemplated, and the reasons therefor, sufficient to permit timely response and the use of established procedures for appeal and review.

D. Re-evaluation
   1. Review - The head of the institution being evaluated is given the 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. Appeal - At the request of the head of the institution, a re-survey may be made. Accreditation decisions may be appealed by letter 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 collaborating organizations. A report form is provided and should be completed, signed by the Director of the Educational Program, and returned promptly.

F. Re-survey - The AMA and collaborating organizations will periodically re-survey educational programs for consultation and re-evaluation.

X. APPLICATION AND INQUIRIES

A. Accreditation - Application for accreditation of a program should be made to:
   Department of Allied Medical Professions and Services
   Division of Medical Education
   American Medical Association
   535 North Dearborn Street
   Chicago, Illinois 60610

B. Careers - Inquiries regarding career information should be addressed to:

   (Name and address of allied health professional association)

C. Registration-Certification - Inquries regarding registration or certification of qualified graduates of the accredited program should be addressed to:

   (Name and address of the Registry)

4/13/71

THE PHYSICIAN'S ASSISTANT

This document is a description of the role and projected activities for the assistant to the Primary Physician. It was prepared by a Task Force of representatives from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Society of Internal Medicine for presentation to the American Medical Association to provide data required under Guidelines for Development of New Health Occupations. It is designed to supply the views of the physicians who will be working with the assistant about his activities and requisite skills. It does not contain the specifics of training programs nor curricula, but defines the role and status of the assistant for educational institutions desiring to initiate training programs.

In this document the assistant described will be referred to as the physician's assistant to the primary physician or the primary physician's assistant. The Task Force recognizes that there are disagreements concerning nomenclature and terminology in the allied health professions and believes that definitive clarification of nomenclature is beyond the scope of the Task Force.

The Task Force further recognizes that various levels of physician support personnel have been described. The assistant described in this document will be highly skilled in aspects of patient care, and corresponds to the highest level of allied health worker in the various hierarchies: the level A assistant of the National Academy of Sciences (1), and the associate in the hierarchy - associate, assistant, aide. This document will not be addressed to need for or activities of lower levels of physician support personnel.

1. Role, projected activities, and scope of duties.

The mission of the physician's assistant is to provide, under the direction and supervision of a licensed physician, selected diagnostic and therapeutic tasks, to allow the physician to extend his services to a greater population base through the more effective use of his knowledge, skills and abilities. The addition of this new health professional is an attempt to bring high level personal medical care to all citizens through an extension of services of the primary physician, not an attempt to give second rate care to some citizens by providing physician substitutes.

The physician's assistant to the primary physician is a member of the allied health professions, who works closely with and under the supervision of a doctor who functions as the primary physician to his patients (family practitioner, internist, pediatrician). His training prepares him to support the physician in his daily activities; many of his duties include functions now done by the doctor.

The physician's assistant will be involved with the patients of his employer in all settings of medical care: the office, the ambulatory clinic, the hospital, patient's home, extended care facility and the nursing home. His work is under the supervision of the physician, who retains responsibility for patient care, although the physician need not be present at each activity of the assistant nor be specifically consulted before each delegated task is performed.

Intelligence, ability to relate to people, capacity for calm and reasoned judgment in meeting emergencies, and an orientation toward service are qualities essential for the physician's assistant. As a professional, his respect for the person and privacy of the patient must equal that of the physician.

The activities of the primary physician in caring for his patients may be classified as follows:

1. Diagnostic services (disease detection).
2. Continuing medical care.
   a. Chronic disease.
   b. Compensated asymptomatic disease.
   c. Pregnancy.
3. Care of acute disease and injury.
   a. Major.
   b. Minor.
4. Rehabilitation.
5. Health maintenance (disease prevention).
6. Community health.

In rendering the services appropriate to these types of care, the primary physician traditionally performs a variety of activities. Among these are some which are essential to his serving the patient and which can be performed only by him; these relate to the application of his intellect and skill toward logical and systematic evaluation of the patient's problems, integration and analysis of data necessary for solution of the patient's problems, and use of judgment in planning a program of management and therapy appropriate to the patient. The physician's assistant 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 therapeutic plan for the patient.

The tasks performed by the physician's assistant are those which require technical skills, execution of standing orders, routine patient care tasks, and such complicated diagnostic and therapeutic procedures as the physician may wish to assign to the assistant after he has attained and demonstrated his proficiency through adequate instruction and for whose action the doctor is willing to accept responsibility. The physician's assistant is responsible for keeping complete records of all events and results of encounters with patients, whether by direct contact with patients or by telephone. These entries should be consistent in format and content with the entire record which is kept on the patient.

The practice of medicine is the responsibility and prerogative of the physician with whom the physician's assistant works. It should be understood by all members of the medical care team and explained to patients that the assistant makes decisions and executes tasks assigned by the physician.

The primary physician is responsible for the management of the total and continuing health care of the patient, rather than limited or episodic care. The physician's assistant will be involved with helping the doctor in the total health care of the patient, the elements of which are:

Diagnostic Services - The physician is necessarily involved early in the diagnostic process, but the physician's assistant may collect historical data of present and past health problems and perform portions of the physical examination before presenting the patient to the physician. The assistant may schedule, perform and assist in diagnostic studies and measurements as tonometry, Pap smear, breast examinations, and protoscopic examinations.

Continuing Medical Care - The physician's assistant makes observations appropriate to the patient's underlying disease or state (pregnancy) and treatment plan. He reviews the patient's medications, diet, course of therapy, and adherence to management plan. The assistant is able to instruct and counsel patients on aspects of common diseases and problems, physical therapy instruction, and home therapy.

Minor illness and injury - The physician's assistant is trained to offer telephone advice to the patient and schedule an appointment if indicated. He obtains a history of the illness and after appropriate examination can initiate appropriate study to facilitate the M.D.'s contact with the patient. He can prepare the patient for and assist in minor surgery.

Major illness and injury - The assistant is largely involved in performing under direction of the physician studies designed to evaluate the patients' problem and aiding in emergency care. He assists the physician in definitive management of surgical, orthopedic, and obstetrical problems.

Rehabilitation - The assistant serves as an extension of the physician by visiting the patient in the extended care facility and the nursing home, where he will review the status and course. He participates in implementing the plan to restore the patient to health and productivity.

Health Maintenance - The assistant will be involved with health evaluations on relatively well adults and in periodic infant and child health evaluations; he will take and record the history of previous illnesses, the family history and the review of systems. He will make and record observations about the growth and development of the younger patient. He will perform portions of the physical examination and present the history, his findings and impressions to the M.D. He will review the immunization status of the patient, review the health habits of the patient, performing a health hazard appraisal and counselling the patient or family regarding tobacco, alcohol, drugs, obesity, mental health, contraception, etc. He will be able to instruct and counsel the family on feeding problems, child rearing and development, accident prevention, sex instruction, etc. As medicine itself develops newer approaches to emotional problems, he will be involved in assisting the physician in counselling patients about mental health, adjustments of adolescence, problems of aging, etc.

Community Health - The assistant must be aware of the community's various health facilities, agencies and resources to facilitate the physician's referral of appropriate patients. As an informed citizen, with a background and skills in health care, he should work toward improving the community's health resources, and offer his services to appropriate community projects and activities.

II. Need

The primary physician is the physician of first contact for his patients and accepts responsibility for the over-all management of the patient's medical care. Virtually all family practitioners and pediatricians, most internists, and some obstetricians serve as primary physicians. The evidence supporting a need for additional physicians in the United States has been well publicized (2). Medical school enrollments have expanded and will reach 12,000 first year students in 1975; yet, it is estimated that 145,000 physicians must enter active practice in the decade 1970-79 to maintain current ratios of physicians to population (3). The effects of medical specialization and the numbers of medical school graduates who enter careers in research, teaching, and administration reduce the number of potential primary physicians. Further, there is geographic maldistribution of physicians. The major need is for an increase in primary physician services; this need may be approached through an increase in the effectiveness of the primary physician by delegation, under supervision, of some activities to appropriately trained physician support personnel.

In 1969 there were 65,300 family or general practitioners in non-federal practice. The American Academy of Family Practitioners believes that there is need for one general practitioner for each 2,000 persons, and that in 1969 there was need for 100,300 general practitioners. They project a need for 115,000 family or general practitioners by 1975, and using a rough estimate of a net increase of 7,000 physicians per year over the next 5 years, point out that there will be a shortage of 28,000 family doctors in 1975 even if 50% of the new physicians enter family practice.

The attitudes of physicians concerning the delegation of elements of their practice to trained assistants under supervision indicates a high degree of acceptance of the concept of the physician's assistant and a willingness to share elements of practice traditionally the prerogative of the M.D. In a survey of 3,425 internists active in patient care, the American Society of Internal Medicine found that the internists believed many elements of their practice could and should be delegated to an allied health worker (4). These included recording elements of the history (60% willing to delegate), home visits (65%), patient instruction (70%), nursing home visits (43%), performance of Pap smears (34%). The American Academy of Pediatrics in a survey of 5,799 pediatricians found that over 70% favored delegation of such activities as recording elements of the history and counselling on child care, feeding and development (5). More than half felt that an allied health worker should make home visits in follow-up of acute illnesses and in patients with chronic disease and should provide medical advice on minor medical matters. A smaller, but significant, number favored delegating well child examinations (25%); sick child examinations (20%), and newborn visits to maternity hospitals (32%).

In both of these studies, as well as that performed in the field of obstetrics (6), there is a wide gulf between what the physician feels he could and should delegate and what he actually does. More than half the pediatricians feel that lack of trained workers is a very serious obstacle to delegation of tasks. The internists indicated that they were equally willing to have patient care tasks traditionally restricted to the M.D. carried out by an R.N. or a physician's assistant with a slight preference for the physician's assistant in physical examination and patient follow-up, and for the nurse in therapeutic activities. Despite the professed willingness to entrust such activities to the nurse, such delegation is rarely done in the 40% of internists' offices which have an R.N.

Coye and Hansen (7) queried 1,345 Wisconsin physicians about their attitudes toward the "doctor's assistant" and found a high percentage who indicated a need for such an individual (55% of family practitioners, 66% of pediatricians, 64% of internists) and willingness to use them in their practices (42% of family practitioners; 41% of pediatricians; 44% of internists). Forty-one per cent of pediatricians (5) indicated that they would hire a full-time allied health worker (type not specified) if available.

The House of Delegates of the American Society of Internal Medicine in 1970 adopted the policy that there is need for the physician's assistant, trained to support the internist in his clinical activities; that the use of the physician's assistant can increase the internist's productivity; that the use of the physician's assistant should not impair the quality of patient care; and that the use of the physician's assistant should not increase the costs of medical care. In 1970 the Congress of Delegates of the American Academy of Family Physicians endorsed the concept of a physician's assistant specifically trained as an assistant to a family doctor to increase his productivity, but in no way to substitute for or replace the primary general practitioner/family physician. The Board of Regents of the American College of Physicians endorsed in principle the 1970 report of its Committee on Community Service describing the physician's assistant, his duties, and activities.

Acceptance of the physician's assistant by patients and physicians is reported to be good in studies conducted at Duke University with the least acceptance by patients in the lowest income and educational levels (8). Ninety-four per cent of parents expressed satisfaction with the combined care provided jointly by a pediatrician and a pediatric nurse practitioner; 57% found joint care better than that which they had received from a physician alone (9).

III. Education and Training

It is not the intent of this Task Force to describe a specific educational program for the primary physician's assistant. The members of the Task Force believe that educational bodies should devise a curriculum and an educational program whose graduates will have the requisite knowledge and skills to serve as the physician's assistant described here.

The Task Force believes that clinical affiliation is an essential element of any educational program for the physician's assistant and that the academic experience should be in programs supervised by physicians qualified for such educational responsibilities. We envision that the clinical training will best be conducted in a model practice unit in a medical teaching center (university affiliated or community teaching hospital). A secondary benefit of having such programs in clinical teaching centers is the simultaneous education of the primary physician in training about supervision and management of allied health workers.

Institutions planning educational programs for the primary physician's assistant should plan from the inception for programs for continuing education for their graduates.

The educational program should be so structured that its graduates will be able to seek advanced training in the health professions or change to another health field at a similar level of training and skills without the necessity of complete re-education. Similarly, there should be provision made for admission to primary physician's assistant programs with advanced standing of those individuals with a background in the health sciences.

IV. Employment

Currently available data indicate a probable starting salary of $9,000 - $12,000 annually for the physician's assistant. Remuneration of the physician's assistant should be through salary from the employing physician, group practice, or medical institution.

Aside from the previously cited figures which indicate that 40% of pediatricians need trained allied health workers and that some 40% of Wisconsin primary physicians would use physician's assistants, there are no data on substantiated employment opportunities. The demand for graduates of physician's assistant programs now in effect (Duke University, MEDEX) far exceed the number of graduates.

The geographic area of greatest potential employment is seen as those areas where the primary physician is hardest pressed, rural, small town, central city areas, although it is likely that many overworked suburban physicians will also wish to employ assistants. As increasing numbers of group practices are established, it is likely that they will incorporate the physician's assistant into their team approach to patient care.

V. Professional Certification

The Task Force does not favor licensure of the physician's assistant. We believe that there should be established a Board composed of representatives of the following groups: AMA, the specialty organizations representing the primary physician, and at a necessarily later date the professional organization of the primary physician's assistants. This Board will have the functions of evaluation and accreditation of training programs for the primary physician's assistant, examination and certification of graduates of the training program, establishing and monitoring program for continuing education of graduates of primary physician's assistant programs.

VI. Career, Education and Geographic Mobility.

The Task Force believes that the profession of physician's assistant should be a career, whose skills, role satisfactions, and financial recompense are sufficient to attract and retain men and women who are the heads of households. While the Task Force believes that being a primary physician's assistant should be a satisfying life-long career, his education should be structured to permit entry at advanced standing into education for another health profession should his ability and motivation dictate. Graduation from an accredited program and possession of a certificate of competence as a primary physician's assistant should permit his location or relocation in any part of the United States.

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Didnot distinguish between
Types A and C

There are others working
on the Type B essentials

The essentials have to say

1) the two year programs absolutely meet the requirements

2) other programs may be provisionally approved until

APPENDIX

Representative activities of the Physician's Assistant in the various settings for medical care.

I. Office

A. Patient's History

1. New patient - A part of the comprehensive exam may be assigned. Take and record elements of past medical history, family history, review of systems, health habits, environmental and occupational data.
2. Periodic health exam evaluation - record interval illnesses, past history, as under new patient.
3. Evaluate computer generated or patient self-administered history for significant entries.
4. Old patient - Review, record, and verify details of therapeutic program, review and record interval history.
5. Patient with acute illness - Review pertinent history for presentation to physician.

B. Physical examination.

1. Health evaluation - asymptomatic patient - General physical examination. Evaluation of growth and development.
2. Acutely ill symptomatic patient - Pertinent screening examination for presentation to M.D. to facilitate appropriate diagnostic study.
3. Old patient - chronic disease - Examination for pertinent abnormalities (evidence of cardiac decompensation, arrhythmia, BP, joint mobility).
4. Prenatal visits - evaluation.
5. Acute injury - Examination for extent and nature of injuries, evidence of shock, to facilitate diagnostic studies and prompt management. Initiate supportive management.
6. Special studies, assisting in: Pelvic exam - Pap smear
   Visual testing - acuity, fields, tonometry.

C. Laboratory and Related Studies

1. Draw venous blood samples.
2. Perform blood counts.
3. Perform urinalysis.
4. Perform stool examination.
5. Injection of test substances (BSP, IVP dye)
6. Perform EKG.
7. Pulmonary function testing.
8. Instruct patient on obtaining specimens.
9. Perform skin tests.
10. Perform bacteriologic smears and cultures.

D. Therapeutic duties
   1. Injections.
   2. Immunizations.
   3. Assist in chronic disease management as outlined by standing orders of M.D.
   4. Cleanse and dress wounds.
   5. Suture wounds.
   6. Remove sutures.
   7. Application of casts - splints.
   8. Topical dermatologic therapy.
   9. Inhalation therapies
   10. Catheterize patients.
   11. Ear irrigations.

E. Patient contact duties.
   1. Counselling - health habits; exercise, tobacco, alcohol, supportive counselling.
   2. Instruction on physician's orders - diet
      Physical therapy
      use of physical adjuncts to therapy -
      Prenatal instructions
      Child care instructions
   3. Telephone contact and advice, scheduling appointment if necessary.

F. Administrative - clerical activities
   1. Maintain clinical records.
   2. Inventory supplies reorder as necessary.
   3. Fill out insurance forms, school and work forms, etc.
   4. Schedule tests.
   5. Schedule hospital admissions.
   6. Schedule appointments with consultants.
   7. Schedule return visits.
   8. Explain health insurance benefits, etc.

II. Hospital-Assist physician employer in management of hospitalized patients.
   A. Check on clinical status of patient.
   B. Explain projected tests, therapy.
   C. Report on progress.
   D. Check on report of studies.
   E. Assist in documentation of care - within limits of hospital regulations.
   F. Transfer hospital data to office records.

III. Extended care facility of convalescent patient's home
   A. Record data from hospital - office, assist in documentation of care.
   B. Review treatment plan, therapy.
   C. History, physical exam.
   D. Evaluate progress, consult with nurse, physical therapist.
   E. Examine for basic illness, complications, intercurrent illnesses.
   F. Fill out insurance forms, certification of necessity of care, etc.
   G. Obtain blood for testing (prothrombin time, etc.)

IV. Nursing Home or Patient's Home on chronic, bedridden patient
   A. Assist in documentation of care.
   B. History and physical exam.
   C. Examination for basic illness, complications, intercurrent illness, emotional impact of illness.
   D. Review treatment plan.
   E. Administer IV fluids.
   F. Insert feeding tube.
   G. Change catheters.
   H. Remove fecal impaction.
   I. Order necessary studies.
   J. Fill our insurance forms, certification for necessity of care, etc.

V. Patient's home - acute illness
   A. Assist physician in therapy - accompany patient to hospital if necessary
   B. When physician not present, evaluate patient status, consult with physician by phone about therapy and plan for patient
   C. Assist family in adjusting to situation.

ADOPTION OF ESSENTIALS

The usual procedure in developing the requirements for AMA approval for an allied health occupation is:

1. Name the occupation.

2. Identify the medical specialty and other organizations involved.

3. List the tasks which the allied health worker will be expected to be able to do.

4. Using the standard format for *Essentials*, identify the kinds of educational settings and programs which can prepare students to do the tasks listed in No. 3.

5. The medical specialty and any other organizations specifically concerned, such as the Association of American Medical Colleges, review the draft for *Essentials* and, if approved, formally endorse the draft. An officer of each organization sends a formal letter of endorsement to the AMA Council on Medical Education.

6. American Medical Association procedure:

   a. The Advisory Committee on Education for the Allied Health Professions and Services reviews and recommends action to the Council on Medical Education.

   b. The Council on Medical Education reviews the draft and includes it in a report to the AMA House of Delegates.

   c. The Council on Medical Education's report, including the complete text of the proposed *Essentials*, is reproduced in an agenda book mailed to the Delegates and Alternate Delegates sixty days before their meeting (the House of Delegates meets twice each year).

   d. At the convention, the House refers the proposed *Essentials* to a Reference Committee. The next day, the Reference Committee holds public hearings, and writes a written report which is reported orally to the House. The Reference Committee may recommend that the proposed *Essentials* be adopted.

   e. The AMA House of Delegates votes its adoption of *Essentials*.

7. The *Essentials* are published by the AMA and the collaborating organizations.

8. The additional collaborating organizations add themselves to those already working together for allied medical education.

9. The president of each additional collaborating organization designates a Consultant to serve on the Panel of Consultants of the Advisory Committee on Education for the Allied Health Professions and Services.

10. The collaborating organizations sponser a joint review committee, which arranges for survey teams to accept invitations to visit educational programs to provide services, including a recommendation concerning accreditation.

11. The AMA Council on Medical Education and the collaborating organizations approve acceptable educational programs and publish lists of approved programs.

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I. Educational programs may be established in:

A. Medical Schools

B. Military Educational Facilities of the Department of Defense ~~teaching facilities~~

C. Colleges or universities affiliated with an accredited CLINICAL teaching facility.

D. Accredited teaching hospital and/or associated clinics affiliated with an educational institution.

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THE PHYSICIAN's ASSISTANT

I. Role, projected activities, and scope of duties.

The mission of the physician's assistant is to provide, under the direction and supervision of a licensed physician, selected diagnostic and therapeutic tasks, to allow the physician to extend his services to a greater population base through the more effective use of his knowledge, skills and abilities.

The Assistant to the Primary Care Physician is an allied health professional, which works closely with and under the responsibility and supervisor of a doctor who serves as the primary physician to his(her) patients. His preparation prepares him to support the physician in his daily activities, who do not require a specific knowledge and preparation of the the physician.

The Assistant to the Primary Care Physician will be involved with the patients of his supervising physician in all settings of medical care. His work is under the supervision of the physician who retains responsibility for patient care.

In rendering the services appropriate to these types of care, the primary physician traditionally performs a variety of activities. Among these are some which are essential to his serving the patient and which can be performed only by him; these relate to the application of his intellect and skill toward logical and systematic evaluation of the patient's problems, integration and analysis of data necessary for solution of the patient's problems, and use of judgement in planning a program of management and therapy appropriate to the patient. The Assistant to the primary 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 therapeutic plan for the patient.

The tasks performed by the Assistant are those which require technical skills, execution of standing order, routine patient care tasks, and diagnostic and thereapeutic procedures as the physician may assign to the assistant after he has attained and demonstrated his proficiency through adequate instruction and experience and whose action the doctor is willing to accept responsibility.

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The primary physician is responsible for the management of the total health care of the patient, rather than limited or episodic care. The assistant will be involved with helping the doctor in the total health care of the patient.