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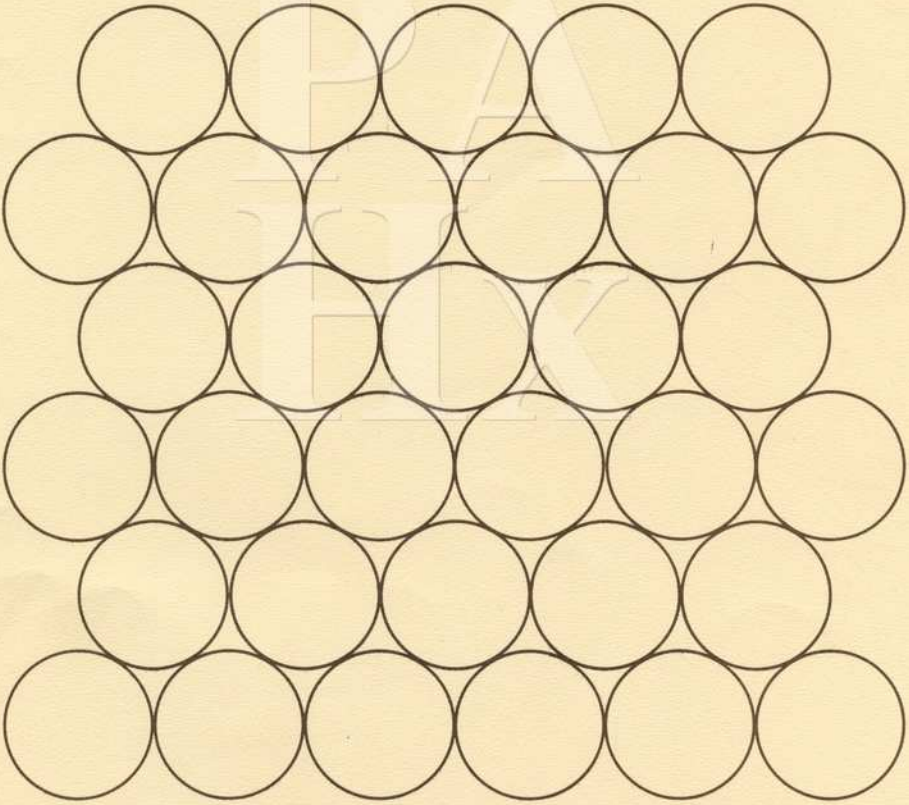
Guidelines for Educational Programs for the Assistant to the Primary Care Physician

February/1974



American Medical Association / Division of Medical Education / Department of Allied Medical Professions and Services

G U I D E L I N E S

FOR EDUCATIONAL PROGRAMS FOR THE

ASSISTANT TO THE PRIMARY CARE PHYSICIAN

February 1974

The Joint Review Committee on Educational Programs
for the Assistant to the Primary Care Physician

and

The Council on Medical Education

GUIDELINES FOR EDUCATIONAL PROGRAMS FOR THE ASSISTANT TO THE PRIMARY CARE PHYSICIAN

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PREFACE

Standards for educational programs preparing assistants to primary care physicians were adopted by the American Medical Association's House of Delegates in December 1971, having been developed collaboratively by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Society of Internal Medicine. These organizations sponsor the Joint Review Committee on Educational Programs for the Assistant to the Primary Care Physician. The Committee is composed of three representatives from each of the sponsoring organizations and three graduate physician's assistants who it appointed to serve for one-year terms in April of 1973. The Committee receives and evaluates applications for program accreditation on the basis of established *Essentials*. The American Medical Association's Council on Medical Education accredits programs upon recommendation from the Joint Review Committee.

Essentials are a statement of policy and as such constitute minimum standards of quality in educational programs that are recognized by accreditation. The *Guidelines for Educational Programs Preparing the Assistant to the Primary Care Physician* describe how the *Essentials* are interpreted and are illustrative of their flexibility and accomodation of different approaches to the design and conduct of educational programs preparing assistants to primary care physicians.

Educational programs meeting the minimum *Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician* provide curriculum content, faculty, and other resources which allow students the opportunity of acquiring knowledge and skills in selected functions and tasks within primary care and with the ability to perform within competency levels equal to that of physicians. Quality of personal health services is not compromised by virtue of the fact that the physician only delegates and the assistant to the primary care physician only assumes responsibility for the performance of functions or tasks in which he is competent.

The assistant to the primary care physician may be best understood within the context of the following statements adopted respectively by the AMA House of Delegates and the Joint Review Committee on Educational Programs for the Assistant to the Primary Care Physician:

> A physician assumes the role of a primary care physician when the patient depends on him for the initial access to and for the provision and overall management of his medical care. The same physician may not invariably continue in this role, but by referral, another physician may assume it. In any specific health matter, the particular physician who accepts a patient for primary care should assume continuing supervision of that care.
>
> This relationship may also be carried out by a group of physicians who function in a defined, responsible pattern of medical practice.

In such a type of practice a single physician, however, should maintain an ongoing relationship with the patient, and should coordinate his care.[1]

The primary care physician is one whom the patient generally consults directly, and whose practice is characterized by a broad scope of medical services, including the management of acute problems, slowly progressive and chronic illness, preventive and emergency services, and personal and family counseling. It is also recognized that the primary care physician is often the one to whom a patient turns for counseling on personal life situations as well as with his concerns about illness or injury.

It is in the common problems above, that the assistant to the primary care physician should receive basic preparation and skills.[2]

[1]Adopted November 1972 by the American Medical Association's House of Delegates.

[2]The statement is an adaptation of a description published in The New England Journal of Medicine, Vol. 282, No. 15, pp. 871-872, April 9, 1970.

ORGANIZATIONAL SPONSORSHIP OF EDUCATIONAL PROGRAMS

The *Essentials*[3] recognize that educational programs of basic quality may be established and operated successfully under a variety of administrative auspices. Among the optional organizational bases are:

Medical Schools and academic medical centers;
Senior colleges and universities in affiliation with an accredited teaching hospital;
Medical education facilities of the federal government such as Veteran's Administration hospitals, U.S. Public Health Service hospitals and agencies, and the military services; and
Other institutions with clinical facilities, which are acceptable to the Council on Medical Education of the American Medical Association. (These include junior and community colleges in affiliation with accredited teaching hospitals, and accredited teaching hospitals in affiliation with an accredited educational institution.)

The Institution should be accredited or otherwise acceptable to the Council on Medical Education. Senior colleges and universities must have the necessary clinical affiliations. (Essentials I)

The acceptability of these organizational bases may be suggested or attested to by other accrediting bodies such as the Liaison Committee on Medical Education or regional education accreditation bodies.

Experience to date suggests the following general observations, each of which is subject to exception in existing practice:

Academic medical centers, medical schools, and larger academic institutions, by nature of their size, often have a broader range and greater depth of resources with consequent potential for contribution to the didactic and practical education of physician's assistants. This is true not only of the usual faculty resources associated with clinical medicine, but includes as well more faculty who are knowledgeable in communication skills such as listening, interviewing, and counseling, and those faculty knowledgeable in the behavioral sciences.

Traditionally primary care has not been a major focus of the academic medical center, although exceptions to this generalization are increasingly apparent. The emphasis of institutional activities in the academic medical center has traditionally been on secondary and tertiary care. As a consequence, some believe that extra efforts have to be taken to insure that physician's assistant students become imprinted with a primary care orientation, when the

[3]All direct quotations from the *Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician* will hereafter be in italics.

institutional priorities and faculty interest are likely to be on the evaluation and management of acute care problems arising from less common manisfestations of disease and illness. Students have to receive a substantial body of instruction and supervised clinical experience in the evaluation and management of patients who have degenerative diseases and health maintenance problems that are characteristic of primary care.

It is a program's duty to assure students of adequate direct access to patients. By coordinating scheduling with medical school and other health sciences faculty, several programs have arranged to minimize the competition among medical students, junior house staff, student physician's assistants, and other students for clinical contacts with patients. There can be, and reportedly often develops, complementary tutorial relationships among medical and physician's assistant students by virtue of a quid pro quo that exists as a result of differing educational and clinical experience backgrounds.

Affiliations with community hospitals often increase student access to patients, due to the absence of medical students and fewer, if any, house officers. These affiliations are valuable also, in that students receive greater concentration of clinical experience in the care and management needs of patients with the more ordinary manifestations of an acute illness.

When smaller institutions, agencies, and clinics develop a special education program like that for the physician's assistant, special attention and effort are required in obtaining the scope and quality of clinical affiliations necessary for the practical instruction of students. Such organizations may have a strong understanding and concern for the delivery of primary personal health services and through creative efforts develop an educational program which produces competent physician's assistants.

It is important that any program, regardless of organizational sponsorship, prepare assistants to the primary care physician with those attitudes, skills, and knowledge which are fundamental to caring for persons in need of primary health care services. The commitment of the program administration and faculty to such a primary care orientation is fundamental to the success of any program.

THE ADVISORY COMMITTEE

An Advisory Committee should be appointed to assist the director in continuing program development and evaluation, in faculty 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. (*Essentials V,E*)

It is strongly suggested that an Advisory Committee include diverse orientations that bring a breadth of perspective from the program administration and faculty, local primary care physicians, students, graduates, nurses, preceptors, faculty from other departments, representation from the state medical society and the like. Appointments of local primary care physicians to the Committee are considered especially helpful.

By definition, the Advisory Committee advises and as such serves as a sounding board for program plans, for modifications, and for evaluating the purpose and objectives of the program as well as alternative approaches to resolving certain problems in program operation or progress.

Advisors promote understanding of program objectives among their constituent bodies and provide a means of maintaining a higher level of awareness and support for the program among significant groups within the professional community and the community at large.

CURRICULUM

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 tasks, functions, and duties implied in the "Description of the Occupation" above. (*Essentials VIII, C, 1*)

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. (*Essentials VIII, C, 4*)

Both the clinical didactic and clinical practicum components of the curriculum should focus on the knowledge, skills, and attitudes related to the health care needs and concerns that adults, teenagers, and children commonly bring to the primary care setting.

Both components of the curriculum should include the preparation of assistants to primary care physicians who can make knowledgeable and skilled life-saving responses to life-threatening situations: e.g., trauma, acute coronary distress, precipitous delivery, suicidal risk, et cetera.

Skill development in interviewing, listening, and counseling are recognized as important components of clinical competence in primary care, not only in relation to eliciting a personal health history, but in helping individuals arrive at practical approaches to the maintenance of their own health, and in responding to those who express concerns about other than health-related problems.

Clarity in definition of program objectives is fundamental. Preferably, the objectives of each course, and ultimately each class session may be defined so that there is full understanding among faculty and students of what is to be taught and what is to be learned in any given session of instruction. Evaluation processes should be developed to assure the student that he obtains the level of understanding and performance that are basic to the assistant to the primary care physician.

A program cannot evaluate the knowledge and proficiency which students have acquired unless it has first defined the specific functions and tasks they are expected to learn. As a consequence, a program must define course objectives

in such a way that the students, faculty, and evaluator can recognize the level of proficiency and knowledge students are expected to attain from various courses and the program as a whole. For example, objectives might be differentiated in varying levels according to those that require a high level of knowledge and proficiency in the performance of given functions or tasks, those requiring a working knowledge and skill level upon which proficiency could later be developed and those requiring only an awareness of the function of a given level of knowledge and/or skill.

Programs should examine carefully the prior educational and vocational experience of each student in order to reduce the redundance of instructional efforts and the length of time spent by students in the curriculum. Use of proficiency measures should be developed for appropriate placement of students and to give credit for previous accomplishments of learning.

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.

Instruction should stress the role of the assistant to the primary care physician relative to health maintenance and primary care. (Essentials VIII, C 2)

Primary care by its nature deals principally with ambulatory patients, and consequently requires that the clinical practicums of a curriculum have major orientation to ambulatory care as characterized by mild or degenerative disease processes. However, primary care physicians also manage the care of many patients through an acute phase which requires hospitalization. It is in this context that instruction of physician's assistants should include clinical didactic and clinical practicum components dealing with the usual features of the care and management needs of hospitalized patients. It is desirable that students receive similar instruction relating to patients in extended care facilities and in home health services to acquire an appreciation of the value of the care of the patient in his own environment.

It is desirable that graduates have a functional understanding of personality development and of normative human behavior. Courses incorporating content regarding psychosomatic manisfestations of illness and injury; child development; normative psychological and physiological responses to stress in daily living; human sexuality; and the social responses to dying, death, and the surviving spouse are illustrative of behavioral science content which has a strong practical relation to the substance of primary care.

Through his clinical education the student should receive a thorough orientation to the range of responsibilities and functions expected of the assistant to the primary care physician as well as to how to work with the physician and other health service personnel in a variety of patient care settings.

Attention should be given to preventive medicine and public health and to the social and economic aspects of the systems for delivering health and medical services. (Essentials VIII, C, 2)

It is in the context of preventive medicine that skill development in counseling has significant potential for helping patients follow prescribed treatment

regimens or to modify their attitudes and behaviors to more healthful patterns. These skills are fundamental also in making health hazard appraisals for individual patients.

There is need also for graduates to have an understanding of the personal, social and economic consequences of decisions relating to options in the management of personal health, both in its maintenance and in its restoration. A survey course descriptive of the variety of organizational approaches to the delivery of personal health services and of the impact of social and economic factors on physical and emotional well-being is desirable.

> *Throughout the educational experience 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. (Essentials VIII, C, 2)*

Evaluation

Although it is recognized that in many respects contemporary evaluation methodologies are not fully adequate, within the best means available, educational programs must develop and implement evaluation of all phases of training. In addition, the program should assume responsibility for evaluating the graduate's performance as an indication of the adequacy and appropriateness of the training.

Programs should be encouraged to develop behavioral objectives for clinical experience as well as for the courses offered during the didactic phase of the program. Any effort to assess student performance should be made in relation to stated objectives.

It is recommended that, where possible, the evaluation be undertaken on a collaborative basis with similar programs in order to enlarge the numerical size of the sample population.

The Length of the Program

> *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." (Essentials VIII, A)*

The length of the educational program is determined largely by its objectives and complementing student selection criteria. Although they are not restricted to this time frame, programs are commonly 24 months in length with principal, if not total, focus on clinical didactic and clinical practicum instruction. Programs range from 12-45 months in length. (See the section on Student Selection.)

Significant Adjuncts to Curriculum

A "model unit of primary medical care" such as the models used in departments of family practice in medical schools and in family practice residencies, should be used in a clinical practicum so that the medical student, the resident, and the PA student can jointly share educational experiences in an atmosphere that reflects and encourages the actual practice of primary medical care. (Essentials VIII, C, 3)

It is preferred that the physician's assistant student receives exposures to staff who are experienced primary care physicians, graduate physician's assistants, nurses, and the various other health personnel who function within a model practice setting. Scheduling of staff and patients should assure that the student has sufficient access to patients in order to develop his skills in identifying their health status and in assessing their health care needs.

It is helpful to students to receive a portion of their practical clinical experience in one of a number of settings recognized as models for the delivery of primary care when such a unit is accessible to the program as a clinical affiliate. For example, the following definition is exemplary of a model unit of primary medical care and is from the 1971 edition of a Guide for Residency Programs in Family Practice, published by the Residency Review Committee for Family Practice.

> A model unit of primary medical care is a facility used in the education of resident physicians in family medicine. Such a facility is characteristic of family practice offices, with enough rooms to provide each resident the use of a private consultation room, an examination and treatment room or a minor operating room at almost any time he needs them. In addition, there is an attractive and comfortable reception room a nurses' station, a receptionist and/or secretary's area, and a conference room and/or a library used for teaching purposes. If laboratory and x-ray facilities are not within the unit, they are readily available to the patients. Whether in or out of the hospital, the unit is a distinct entity. The unit is reasonably near the parent hospital in which the resident cares for most of his hospitalized patients.

Methodologies and Practices

Instructions 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. program. (Essentials VIII, B)*

As mentioned earlier, evaluation protocols should be established to insure that the student develops command of the knowledge and skills required of an

assistant to the primary care physician. This allows the faculty to identify specific areas of weakness, and to strengthen the student's command of subject matter or clinical skills.

PRECEPTORSHIPS

> *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.*
> *(Essentials V, D, 2)*

Programs commonly arrange for students to spend a portion of their advanced training in one or more preceptorships.[4] These range from one to several months in duration, depending upon program objectives for the preceptorship. Principally, they are intended to accelerate the development of the student's clinical knowledge and skills and his ability to respond to individual patients and their clinical problems and situations.

Representative criteria for the selection of preceptors commonly include evidence of interest in teaching; ability to teach; the primary care focus in the given medical practice; understanding and commitment to the use of physician's assistants in the primary care setting; and the availability of physical space for the student to interview and examine patients.

The purpose and objectives of preceptorships should be committed to writing in clearly stated language in order to minimize the opportunity for misunderstanding among program administration, preceptors, and students; to provide a basis for evaluation of the relevance of the objectives to the development of student's knowledge and skills; to evaluate the student's achievement resulting from the preceptorship; and to evaluate the degree to which the preceptor and his practice serve and meet the objectives.

This should be supported by evaluation protocols that provide for measurment of the extent of the intended learning which the student experiences as a result of the preceptorship and the extent to which the preceptor meets or exceeds his teaching responsibility to the student.

Evaluation protocols may be more effective when their purpose and methods are understood and supported by preceptors and students.

The time required to administer preceptorships varies in relation to class size, the geographic accessibility of preceptors, the size of the preceptor pool to serve the long-term needs of the program, and the character of physician attitudes regarding physician's assistants.

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[4]In this context, a preceptorship is an assigned clinical practicum under the tutelage of a physician who is experienced and knowledgeable in primary care.

CLINICAL INSTRUCTION SITES

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

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, et cetera) and the educational administrators shall be responsible for assuring that the activities assigned to students in the clinical setting are, in fact, educational.

In the clinical teaching environment, an appropriate ratio of students to physicians shall be maintained. (Essentials II)

In obtaining clinical education, students should have access to patients in adequate volume and in appropriate distributions by sex and age who present the common problems encountered in the delivery of primary care. Students require ready access to patients in order to develop skills in clinical assessment and management and related counseling in regard to (1) the common injuries and pathophysiologies presented by hospitalized patients, (2) family-oriented ambulatory primary care needs, and (3) the crisis intervention in life-threatening situations.

Clinical affiliations should be established only with those settings under competent clinical direction to assure that the student receives a constant assessment of his work.

Clinical education must occur within bona fide clinical settings under competent clinical direction; however, faculty should take advantage of simulated clinical experiences in introducing students to applied clinical knowledge and in the structured development of clinical skills through the use of instructional models or programmed patients.

FACULTY – ADMINISTRATIVE

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

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

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. 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.

The medical director may also be the program director.

When the program 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.
(Essentials V: A, B, and C)

Obviously, a program administration functions most effectively when it has the wholehearted support, both attitudinal and financial, of senior administrative offices as well as the enthusiastic support of its staff.

Within the administrative leaders of the program, there should be a body of work experience in the delivery of primary care services with full understanding and respect for the individuality of the person seeking primary care services. Effective administration requires an ability to work within the medico-political and legal milieu that accompany the change in attitudes and practices within the health services culture which are brought about by the education of physician's assistants.

The general effectiveness of a program is enhanced by the degree to which the administration and faculty subscribe to and actively pursue a process of self-analysis prior to an accreditation on-site evaluation. Such a process involves a critical review of program objectives, the appropriateness of curriculum content in view of those objectives; the effectiveness of the instruction; the adequacy of the resources and facilities devoted to the program; an analysis of the strengths and limitations of the program; and a plan for program improvement. Evidence of a process of program self-analysis is required of the Council on Medical Education by the U.S. Office of Education.

FACULTY – INSTRUCTIONAL

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

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.
(Essentials V, D)

It is imperative that the faculty have an appreciation for teaching with a strong orientation toward clinical problems common to primary care. Instructional faculty may include house staff, medical center clinical staff, and practicing physicians other than medical center-based faculty such as family physicians, internists, obstetrician-gynecologists, pediatricians, surgeons, psychiatrists, orthopaedists, et cetera. The specialists who are usually considered referral consultants in secondary care may be key faculty members by virtue of their specific knowledge in primary care: for example, a psychiatrist who is experienced in primary care such as that provided through a community mental health center. Instruction in the clinical practicum should be provided by faculty members who are experienced in primary care; programs should not rely

chiefly on resident physicians who are still in the formative stages of their development and who usually have only limited experience in the management of primary health care problems.

In addition, students should receive some of their clinical practicum instruction from clinical preceptors as discussed earlier. (See "Preceptorships")

Faculty and preceptor understanding and support for the role of the physician's assistant are critical to the students' development of confidence in this role. Otherwise, students may experience significant stress in grasping their identity as physician's assistants, inasmuch as they are frequently asked by others within the clinical setting to define who and what they are as physician's assistants. Nursing students, medical students, and others seldom are subject to similar inquiry because of the wide variety of nurse and physician role models found within the school and affiliated clinical facilities. Because of the limited number of physician's assistants, it is the exception rather than the rule for physician's assistant students to learn in settings where graduate physician's assistants are working.

Curriculae vita of principal faculty members must be on file.

FACTORS RELATING TO STUDENTS AND STUDENT SERVICES

Selection

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.

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. (Essentials VI, A)

Student selection criteria should be developed in consultation with the advisory and admissions committees. Admissions committees should include a variety of perspectives, including those of student and graduate physician's assistants. Selection criteria should be evaluated periodically to determine what effect, if any, they may have had on student performance or attrition.

Selection criteria may vary, but commonly include such factors as the prospective student's concept of the physician's assistant role, emotional and intellectual maturity, ability to communicate, financial stability, evidence of study skills necessary to handle the curriculum, and indication of the ability to obtain career satisfaction within the profession.

Programs of shorter duration commonly select only those students who have had previous education, training, and/or work experience in the health sciences. (See "Length of Program.")

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 the same clinical setting. (Essentials VI, B)

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.

Student/teacher ratios should vary according to the learning objectives and teaching methods used in any given instructional period. The appropriate ratio of students to teachers varies according to the instructional objectives of the various components of clinical instruction. Of principal concern is that the students receive not only the individualized or group instruction required to accomplish defined learning objectives, but that tutorial assistance be readily available for clarification and reinforcement as required by one's individual learning patterns.

Counseling

A student guidance and placement service should be available. (Essentials VI, D)

Students should have ready access to faculty for counsel regarding their academic concerns and to professionally qualified staff for counsel about personal concerns and problems.

Student Identification

Students enrolled in the educational program must be clearly identified to distinguish them from physicians, medical students, and students and personnel from other health occupations. (Essentials VI, E)

FACILITIES

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

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

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

In addition to the above resources and to the extent feasible, students should have free access to teaching/learning resources during evening, night, and weekend hours to foster maximum opportunity for study and self-instruction. Accessibility is perceived in terms of economy of time as it relates to students' movements from classroom to laboratory to clinical care settings to the library. [5]

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. (Essentials VII)

Curriculum

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

This synopsis should include the rotation of assignments, and lists of multi-media instructional aids used to augment the experience of the student. (Essentials VII, B)

A brief yet descriptive statement of content of each course should be maintained including a diagramatic description of the given or random sequence of the clinical practicums students receive. Each course description should be complemented with an outline of the student learning that is expected to result from the course instruction. It is best that this expected learning be stated in definitive, behavioral terms.

A listing of multi-media resources should be maintained, identifying those which are available for instructor and student use. Their location, availability and a description of the processes to be followed in obtaining them should be available to help students and faculty gain access to these useful teaching/learning resources.

Student

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

Reports of medical examination upon admission and records of any subsequent illness during training should be maintained.

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[5]Norman S. Stearns, M.D. and Wendy W. Ratcliff, "A Core Medical Library for Practitioners in Community Hospitals," The New England Journal of Medicine, Vol. 280, No.9, February 27, 1969.

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. (Essentials VII, A)

All student records should be maintained with full respect for their confidential nature. It is likely that these student records may be kept in differing locations with one or more offices sharing responsibility for their maintenance, safe-keeping, and the preservation of their confidential nature.

Activity

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

Practical and written examinations should be continually evaluated. (Essentials VII, C)

A quality record system must be maintained to assure each student and graduate of the availability of the records of his academic performance to future interested parties, such as state regulating agencies, certifying bodies, academic institutions in which he may wish to pursue further studies, and potential employers.

Programs are ethically obligated to insure proper administration of these records in active and archive repositories.

FINANCES

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

The institution shall not charge excessive student fees.

Advertising must be appropriate to an educational institution.

The program shall not substitute students for paid personnel to conduct the work of the clinical facility. (Essentials IV, A,B,C)

FURTHER INFORMATION

Applications for program approval and inquiries regarding program accreditation should be directed to the Department of Allied Medical Professions and Services, Division of Medical Education, American Medical Association, 535 North Dearborn Street, Chicago, IL 60610.

Additional information concerning education of physician's assistants may be obtained from the Association of Physician Assistant Programs, Room 356, 2150 Pennsylvania Avenue, Washington DC 20037.

APPENDIX I

Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician

KEY TO CONTENTS

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

Adopted by the AMA House of Delegates
December, 1971

OBJECTIVE: The education and health professions cooperate in this program to establish and maintain standards of appropriate quality for educational programs for the assistant to the primary care physician, 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 programs for the assistant to the primary care physician. Lists of these approved programs are published for the information of employers and the public. Students enrolled in the programs are taught to work with and under the direction of physicians in providing health care services to patients.

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DESCRIPTION OF THE OCCUPATION: The assistant to the primary care physician is a skilled person, qualified by academic and clinical training to provide patient services under the supervision and responsibility of a doctor of medicine or osteopathy who is, in turn, responsible for the performance of that assistant. The assistant may be involved with the patients of the physician in any medical setting for which the physician is responsible.

The function of the assistant to the primary care physician is to perform, under the responsibility and supervision of the physician, 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 therapeutic 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 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 therapeutic 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 varied medical 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,

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

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 on matters 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 evaluative 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 appropiate 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, scientific books, periodicals, and other reference materials related to the curriculum.

IV. FINANCES

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

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 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 accommodate 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 distinquish them from physicians, medical students, and students and personnel for other health occupations.

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 during training should be maintained.
3. Records or 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.

VIII. 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 of topics or 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 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 assitant 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 judgment 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 therefore, 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 and the American Society of Internal Medicine. Recommended changes will be submitted to these collaborating organizations and the American Medical Association.

XI. APPLICATIONS AND INQUIRIES

Applications for program approval should be directed to:

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

APPENDIX II

B I B L I O G R A P H Y

KEY TO CONTENTS

BIBLIOGRAPHY

The following bibliography resulted from a review of the periodical literature listed in the 1972 and 1973 editions of Index Medicus and the Cummulative Index of Hospital Literature. These selections are only a sample of the available bibliographic sources relating to the education of physician's assistants. Brief descriptions of the articles have been included on occasion to amplify the descriptive title of the reference. A number of these selections pertain to undergraduate medical education, but they are included primarily because they deal with subject areas pertinent to PA education and with the understanding that program administrations and faculties may extrapolate those portions especially pertinent to the education of assistants to the primary care physician.

GENERAL BACKGROUND INFORMATION

Beloff, J.S. (MD) and M. Korper (MPH), "The Health Team Model and Medical Care Utilization, " Journal of the American Medical Association, Vol. 219, No. 3, pp. 359-366, January 17, 1972.

The "Effect on Patient Behaviors of Providing Comprehensive Family Health Services" — Tests the hypothesis that the organizational structure of a health delivery system can significantly alter the pattern of medical care behavior of its patient population was tested.

Dean, Winston J. (JD, MPH), "State Legislation for Physician's Assistants — A Review and Analysis," Health Services Reports, Vol. 88, No. 1, pp 3-12, January 1973.

Horseley, A.W., "Physician's Assistant Training Program: Questions and Answers," Journal of the Iowa Medical Association, Vol. 63, pp 155-156, April 1973.

Jones, S., "Some Thoughts on Primary Care:Problems in Implementation," International Journal of Health Service, Vol. 3, No. 2, pp. 177-187, Spring 1973.

Lowe, J.R., et al.,"The Physician's Assistant, Exploration of the Concept," Hospitals, Vol. 45, pp 43-51, June 1, 1971.

This article has an extensive bibliography relating to the physician's assistant through early 1971.

Magraw, R.M. (MD), "Relationships Between Teacher, Student, and Patient," Journal of the American Medical Association, Vol. 224, No. 2, pp 225-228, April 9, 1973.

The social roles, various functions, and the accompanying obligations to those functions are discussed in terms of the relationships between teacher-student, teacher-patient, student-patient, doctor-patient, in the academic medical center, a public hospital, and a private community hospital in an effort to determine which set of variables offers the most personal and effective health care for the patient and education for the student.

Proger, Samuel (MD), "The Education of Different Types of Physicians for Different Types of Health Care," Pharos, pp. 53-66, April 1972.

Rouselot, L. M. (MD) et al.,"The Evolution of the Physician's Assistant: Brownian Movement or Coordinated Progress," The Bulletin of the New York Academy of Medicine, December 1971, pp 1473-1500.

Silver, Henry K. (MD), "A New Primary Care Medical Practitioner," American Journal of Diseased Children, Volume 126, pp. 324-327, September 1973.

Silver, Henry K. (MD) and John E. Ott (MD), "The Child Health Associate: A New Health Professional to Provide Comprehensive Health Care to Children," Pediatrics, Vol. 51, No.1, pp. 1-7, January 1973.

The article outlines the curriculum content and design, prerequisites for admission, and discusses the type of functions performed by the child health associate in the practice setting.

STUDENTS

Crovitz, E. (PhD), et al.,"Selection of Physician's Assistants," Journal of Medical Education, Vol 48, pp 551-555, June 1973.

Fine, L. L. (MD), and P. Machotka (PhD), "Role Identity Development of the Child Health Associate," Journal of Medical Education, Vol. 48, pp 670-675, July 1973.

"This study was designed to determine what professional role identity child health associates had formed during their internship year and to discover which experiences had helped mold the identity...A prominent concern was acceptance by the physician, office staff, and patients."

Knight, James A. (MD), The Medical Student: Doctor in the Making, Appleton-Century Crofts Publishing Company, New York 1973.

The psychological aspects of such subjects within medical school training as "Wearing the Healer's Mantel"and the "Medical Student and Marriage" are included in this book; the primary focus relates to daily routine and frustrations encountered by the medical student.

CURRICULUM — SCIENCE

Basic Sciences

Bloomfield, D.K. (MD), et al.,"Relevance in Teaching Basic Medical Sciences — Preliminary Report of an Approach to Innovation," Illinois Medical Journal, Volume 143, No. 1, pp 32-35+, January 1973.

The article lists basic assumptions of the approach, the organization of the curriculum, the role of the clinical faculty (practicing physicians), the role of the full-time faculty, and the curriculum design; it favors approaching the basic sciences through a series of clinical problems.

Behavioral Sciences

Banks, Sam A. (PhD) and E. A. Vastyan (BD), "Humanistic Studies in Medical Education," Journal of Medical Education, Vol. 48, pp 248-257, March 1973.

Becker, R.E. (MD), et al.,"Psychiatry in the Functionally Organized Undergraduate Curriculum," American Journal of Psychiatry, Vol. 130, No. 5, pp. 571-574, May 1973.

The article favors presenting psychiatry to the student as concepts in their natural context: as they arise in conjunction with disease in the functioning human organ systems.

Morrison, A., and M. Cameron-Jones, "A procedure for Training for General Practice," British Journal of Medical Education, Vol. 6, No. 2, pp. 125-133, February 1972.

Presents methods for forming patient-simulated interviews and favors role-playing and subsequent assessment and evaluation as a means of developing student awareness of the behavioral patterns which will be encountered in the practice setting.

Reister, G. E. and J. G. Boulger (PhD), "Practicing Physicians' Judgements of Curriculum Content in the Behavioral Sciences," Journal of Medical Education, Vol. 47, No. 9, pp 729-736, September 1972.

This study concluded that the content areas perceived most important by practicing physicians are: Human Growth and Development, Psychopathology, Family Dynamics, and Socio-cultural Problems. The article does not amplify on these curriculum areas.

CURRICULUM – COMMUNICATION

Listening

McNichols, Ralph and Lenoard A. Stevens, Are You Listening?, McGraw Hill Publishing Company, New York 1957.

The Art of Listening, Leadership Resources, Inc., (1750 Pennsylvania Avenue, N.W.) Washington, DC 20006.

"How to Listen More Accurately," Zerox Corporation,(Division of Education and Training) Rochester, New York.

Medical Interviewing

Cline, D.W. (MD), and J. N. Garrard (PhD), "A Medical Interviewing Course: Objectives, Techniques, and Assessment," American Journal of Psychiatry, Vol. 130, No. 5, pp 757-578, May 1973.

This article provides a complete course description, from objectives through texts, methods, observations, and evaluation.

Tapia, Fernando, "Teaching Medical Interviewing: A Practical Technique," British Journal of Medical Education, Vol. 6, No. 2, pp. 133-136, June 1972.

This articles considers topics such as learning to deal with silence, empathy, non-verbal communication skills, types of questions, pacing of questions; it is generally geared to an introductory course at the pre-clinical stage of an educational program.

Turnbull, J. M. (MD), et al.,"Evaluating the Paraprofessional," The Canadian Psychiatric Association Journal, Vol. 17, No. 3, pp. 195-198, June 1972.

Describes a study which was undertaken to determine the relationship of interviewing skills to age, educational level, and intelligence; indicates that skill in interviewing is not significantly related to these factors.

Waldron, J., "Teaching Communication Skills in Medical School," American Journal of Psychiatry, Vol. 130, No. 5, pp. 579-581, May 1973.

Counseling Skills

Bloom, M. (MD), et al.,"Interviewing the Ill Aged," The Gerontologist, Vol.11, No. 4, pp. 292-299, Winter (Part 1) 1971

Faigel, H.D. (MD), "Getting Patients to Follow Advice: The Art of Communication," Clinical Pediatrics, Vol. 11, No. 12, pp. 666-667, December 1972.

Kahn, J. H. (MD), "Communication with Children and Parents," British Medical Journal, Vol. 3, pp. 406-408, August 12, 1972.

Korsch, B.M., and V. F. Negrete, "Doctor-Patient Communication," Scientific American, Vol. 227, pp. 66-74, August 1972.

Orvin, G. H. (MD), "Interviewing the Adolescent," The Journal of the South Carolina Medical Association, Vol. 66, No. 8, pp. 282-284, August 1970.

Guidelines are offered as suggestions to aid the physician in developing special techniques for interviewing the adolescent.

Veverka, J. F. (MD), and J. Goldman,(MA), "Rural Family Counseling," Journal of the Iowa Medical Society, Vol. 63, No. 8, pp. 395-398, August 1973.

CURRICULUM — OTHER SUBJECTS

Barton, David (MD), "The Need for Including Instruction on Death and Dying in the Medical Curriculum," Journal of Medical Education, Vol. 47, No.3, pp. 169-175, March 1972.

The article suggests that instruction on death and dying be included at all levels of the curriculum in order to "manage more effectively the responses evoked by this topic, to ensure optimal patient care, a and encourage further study..." Definitive suggestions for implementing this instruction are included.

Barton, David (MD), et al.,"Death and Dying: A Course for Medical Students," Journal of Medical Education, Vol. 47, No. 12, pp. 945-951, December 1972.

This article explaines the manner in which subject matter may be taught: literature, patient presentation; psychological, medical, ethical issues and personal feelings are considered in such aspects as grief and bereavement, palliation, life-threatening illness. This was specifically designed for medical personnel to prepare them to deal with the psychosocial aspects of life-threatening illness.

Bryant, T.E. (MD,JD), and R. D. Cotton (JD,SM), "Issues in Health Care: A New Course for Beginning Medical Students," Journal of Medical Education, Vol. 47, No. 3, pp. 216-218, March 1972.

Garrard, J. (PhD), et al.,"Evaluation of A Course in Human Sexuality," Journal of Medical Education, Vol. 47, No. 10, pp. 772-778, October 1972.

Golden, J.S. (MD) and E. H. Liston (MD), "Medical Sex Education: The World of Illusion and the Practical Realities," Journal of Medical Education, Vol. 47, No. 10, pp. 761-771, October 1972.

Olin, H.S. (MD), "A Proposed Model to Teach Medical Students the Care of the Dying Patient," Journal of Medical Education, Vol. 47, No. 7, pp. 564-567, July 1972.

Rodstein, Manuel (MD), et al.,"A Model Curriculum for an Elective Course in Geriatrics," Gerontologist, Vol. 13, pp. 231-235, Summer 1973.

The curriculum emphasizes the nature and various manifestations of the aging process. It is designed for 75 hours over a three-week period with an emphasis on seminars and patient contact.

Saitz, Edward W (MD), and Kathryn H. Lewis (MD), "Use of the Problem-Oriented Record by Junior Medical Students in Pediatric Ambulatory Care," Journal of Medical Education, Vol. 48, No. 5, pp. 453-455, May 1973.

"The use of the progress-note format to initially formulate problems provides the student with a framework to organize his thoughts ... The process has the advantage of forcing the student to compile and to integrate all available information about a problem...thus adding to his understanding of what is taking place at that point..."

Vandervoot, H. E. (MD), and D. C. Ransom (PhD), "A Basic Course in Family Medicine," Journal of Medical Education, Vol. 47, No. 11, pp. 908-909, November 1972.

This article provides an overview of a course in family medicine including such items as the philosophy for the development, the integrated approach using a balance of behavioral science and medicine content, course goals, structure, and success to date.

Veatch, R. M. (PhD), and W. Gaylin (MD), "Teaching Medical Ethics: An Experimental Program," Journal of Medical Education, Vol. 47, No. 10, pp. 779-785, October 1972.

Vernick, J. J., "Selected Bibliography on Death and Dying," National Institute of Child Health and Human Development, Washington DC. (Available through the U.S. Government Printing Office, 20402)

Ways, P. O. (MD), et al.,"Focal Problem Teaching in Medical Education," Journal of Medical Education, Vol. 48, No. 6, pp. 565-571, June 1973.

This course is designed to provide an introduction to clinical experience. Neither discipline-centered nor organ-system based, it employs a small-group learning format to develop skills of communication, interaction, and evaluation. Includes suggestions for implementation and planning, evaluation of student, progress, relationship to clinical experience, as well as definitive objectives of the program.

CLINICAL EXPERIENCE

Cooper, J. K. (MD), et al., "The Decision for Rural Practice," Journal of Medical Education, Vol. 47, No. 12, pp. 939-944, December 1972.

"In order to identify physicians who might be successfully recruited to rural practice, factors found to be important in a physician's decision about where to locate are reviewed and summarized. Such factors can be classified into three groups: personal, professional, and community. A summary table is presented."

Gamble, T. E. (PhD), "Involvement of Practicing Physicians in the Training of Students - The Illinois Experience," Journal of the American Medical Association, Vol. 224, No. 10, pp. 1412-1413, June 4, 1973.

An editorial on the manner in which practicing physicians are being involved in the training of students: their role, their reactions, and the basic structure of the program.

Metcalfe, D. H. (MD) and J. C. Mancini (MD), "Critical Event Outcome Studies Used as a Teaching Toole," Journal of Medical Education, Vol. 47, No. 11, pp. 869-872, November 1972.

The article assesses doctors responses to clearly defined and well-documented clinical situations (in the forms of algorithms); favors the use of algorithms to help the resident evaluate the patient care of his practice.

Sox, H. C. Jr. (MD), et al., "The Training of Physician's Assistants," The New England Journal of Medicine, Vol. 288, pp. 818-824, April 19, 1973.

The use of a clinical algorithm system for patient care, an audit of performance of physicians and physician's assistants, and the value of this as a teaching tool for education are studied.

Tanner, L. A. (MSW), et al., "An Interdisciplinary Student Health Team Project In Comprehensive Health Care," Journal of Medical Education, Vol. 47, No. 8, pp. 656-658, August 1972.

Werkman, S. L. (MD), et al., "Medical Students View Clinical Psychiatry," The American Journal of Psychiatry, Vol. 130, No. 5, pp. 562-565, May 1973.

SIGNIFICANT ADJUNCTS TO CURRICULUM

Brandon, A. N., "Selected List of Books and Journals for the Small Medical Library," Bulletin of the Medical Library Association, Vol. 61, No. 2, pp. 179-200, April 1973.

Howard, D. R., et al., "Media Utilization and Needs in Physician's Assistant Programs and Related Medical-Health Education" A Report available from the American Association of Medical Colleges, (One Dupont Circle, N.W.) Washington DC, 1973.

Penta, F. B. (EdD), and Sydney Kofman (MD), "The Effectiveness of Simulation Devices in Teaching Selected Skills of Physical Diagnosis," Journal of Medical Education, Vol. 48, No. 5, pp. 442-445, May 1973.

Describes the Iowa opthalmoscopic model, the Bartner eye model, the Strabismus Cover test Demonstrator, and a heart sound simulator, and relates the results of tests for effectiveness of these models in medical education.

Stearns, N. S. (MD) and W. W. Ratcliff, "A Core Medical Library for Practitioners in Community Hospitals," The New England Journal of Medicine, Vol. 280, No. 9, pp. 474-480, February 27, 1969.

EVALUATION

Burra, P. (MB), "Role-Playing," Canadian Psychiatric Association Journal, Vol. 17, No. 3, pp. 188-191, June 1972.

Presents a scale of measuring interviewing skills; the process of developing the scale, including the establishment of inter-rater reliability, is briefly sketched. Application of the scale to medical student performance in interviews revealed that capacity to diagnose and plan management has virtually no relationship to ability to carry on a "good" interview.

Jarrett, J. F. (MB,ChB), et al., "Measuring Interviewing Skills," Canadian Psychiatric Association Journal, Vol. 17, No. 3, pp. 132-188, June 1972.

Quarrick, E. A. (PhD), and E. W. Sloop (PhD), "A Method for Identifying the Criteria of Good Performance in a Medical Clerkship Program," Journal of Medical Education, Vol. 74, No. 3, pp. 188-197, March 1972.

The technique presented does not identify criteria for good performance in any absolute sense, but was intended to provide a means for assigning priorities to a set of variables which are considered important. (This is based on the assumption that teaching programs have their principal impact through the student performance expectations of the faculty, and that quality control can only be brought about by better measurement and understanding of each dimension of the training program.)

Turner, Edward V. (MD), et al., "Evaluating Clinical Skills of Students in Pediatrics," Journal of Medical Education, Vol. 47, No. 12, pp. 959-965, December 1972.

"Good patient care in pediatrics requires, in addition to medical knowledge, a constellation of attitudes and actions which engenders a doctor/patient relationship in which the patient... feels the physician genuinely cares..."

White, K. L. (MD), et al., "Technology and Health Care," The New England Journal of Medicine, Vol. 287, pp. 1223-1227, December 14, 1972.

"Self Analysis Outline for Allied Health Educational Programs," American Medical Association/Council on Medical Education, October 1973. (Available through the Department of Allied Medical Professions and Services, 535 N. Dearborn Street, Chicago, IL 60610)