NEWSLETTER
of the
American Association of Physicians' Assistants

AAPA

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AAPA - INCLUSIVE OR EXCLUSIVE?

E. H. ESTES, Jr., M.D.

One of the difficult problems which lies ahead for the Association is that of defining the limits of its membership. There will be a large number of new health professions arising from the expanding need for health services. There is no reason to think, or even hope, that all will resemble the Physician's Assistant, either in length and scope of training, responsibility, or academic recognition. Some trainees will have broad clinical contacts and responsibilities, and others will have a narrow specialty focus, perhaps confined to a single apparatus (i.e. a dialysis unit) or to a single geographic area (i.e. a coronary care unit).

The Association must, in order to serve its membership with purpose and effectiveness, have a degree of homogeneity of membership, yet it also must achieve size and comprehensiveness. Keeping in mind these dual requirements, what should be the benchmarks for inclusion or exclusion of a given individual, or of the trainees of a given program? This question must ultimately be decided by the membership of the Association, but as an individual with a sincere interest in the future of the Association, I will attempt to list some criteria which seem reasonable and useful at this time.

1. Relation to the Physician: One of the unique features of the Physician's Assistant among the health professionals is that fact that he works directly with the physician, replacing him in some of his activities, and having direct responsibility to him as an individual. This seems to be the most useful single criteria for defining eligibility in the Association. This criterion should allow as much flexibility and variety as is extant within clinical medicine, yet provide clear differentiation between membership in this organization and that in existing professional organizations serving medical technologists, radiologic technicians, etc.

2. Relation to the Patient: Another useful criteria for membership is the fact that the candidate's activity is primarily related to the clinical care of the individual patient. A physician's secretary, for example, is directly responsible to him as an individual, and she may also collect historical data. On the other hand, her activity is primarily related to records, correspondence, and schedules. These are extremely important, yet clearly distinct from the activities of the physician's assistant. A radiologic technician may be responsible to an individual radiologist, and he is certainly concerned about the comfort and safety of the patient, yet his primary concern is with equipment, and with factors leading to a technically acceptable film rather than with the patient's clinical problems. These could be indistinct and potentially sticky differences in specific cases, but the criterion seems generally reasonable and realistic at this time.

3. Formal training: Physicians have always utilized assistants in their clinical activities. Some assistants have had formal training (i.e. the R. N. employed in the physician's office), and others have had no formal training, either didactic or practical. Unique features of the physician's assistant are that he is both formally trained and trained specifically for his role with the physician. The length of training is of less importance than the character and quality of training, therefore it seems reasonable to acknowledge this by the wording of the requirements. Almost all would agree that at least one year of formal training is required, even when of highest quality. Other reasonable requirements would be the fact that due care is taken in selection of candidates, that training includes high quality didactic and practical training, and that the training be specifically directed at preparing the trainee for his role in assisting the physician. A useful measure of the last requirement is the degree of physician involvement in the planning, teaching, and supervision of the training program.

In summary, three criteria are suggested, the last having several parts:

a. The candidate must work directly with the physician, and be responsible to him.

b. The candidate's activities may be general or specialized, but must be primarily centered about the clinical care of individual patients.

c. The candidate must have successfully completed a formal course of training, at least one year in length, specifically designed to prepare him to assist the physician. This course of training should maintain high standards with respect to student selection, instruction, and evaluation, and should contain a major physician input in planning and implementation.

E. H. Estes, Jr., M.D.
Professor of Medicine,
Chairman Dept. of
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Duke University Medical Center.

BRIGHT FUTURE PREDICTED

We have discussed the Physician's Assistant concept with a great number and a wide variety of people during the past few years. However diversified this group, there has been a noticeable similarity in the questions asked. Without a doubt, the most frequent queries are:

1. What is the job description for a Physician's Assistant?
2. What is the legal status?
3. What is the long-range potential for the graduate?

The first two questions have been discussed in previous editions of this journal, so it seems appropriate to turn now to the third question, namely, the potential for long-term job satisfaction.

To answer these questions at this point in time, one must involve the philosophy which permitted us to begin the Program with no clearly identifiable positions available for the graduates and caused us to resist writing the job description prior to the Physician's Assistants' entry into the health field. This philosophy is based on the premise that the medical community has a large job to do and that new members with identifiable skills, dedication, and stability, will be warmly received by most members and career opportunities with job satisfaction will evolve. The job descriptions are now being written because of pressure from management, but they contain an open-

ended feature. Positions available to the Physician's Assistants greatly exceed the number of graduates. Salary ranges exceed our expectations at this point in time. Therefore, time has been a friend to those who joined in this venture. It is my thesis that the same healthy growth curve will continue for graduates of the Program who pursue a career as a Physician's Assistant.

It would have been difficult, if not impossible, for the graduates presently in the field to identify, three or four years back, their present tasks. Therefore, I will not be so foolish as to predict future job titles and descriptions. I will, however, touch base briefly with a few of the general areas which offer real opportunity.

The Physician's Assistant working with the physician in solo practice will grow, with years of experience, to be an invaluable member of the physician's team. He will develop the skills required to support a physician's particular mode of practicing medicine. He can gain the satisfaction, which I am sure the physician derives, from being an active part of the growth and development of the community. He can become knowledgeable in, and assume responsibility for, managing the practice. It is probably in this setting that the Physician's Assistant's impact can be most acutely felt, for only through a highly efficient and effective operation can a solo practitioner survive.

In the group practice of medicine, the Physician's Assistant has the same potential for development in the art of practicing medicine. In addition, as the number of people involved increases so does the need for supervisory skills and personnel stability. In this setting, the Physician's Assistant can develop team members to whom tasks are delegated, thus expanding his impact. There is also the possibility for the Physician's Assistant to move into management since the information acquired during the Physician's Assistant Program and in subsequent years of experience will be extremely valuable in the area of management. Therefore, if you couple this information with a basic understanding of business (which can be acquired formally or informally) you have an excellent foundation on which to build.

Some additional areas which offer a great deal of promise are:

1. Industrial medicine, where we are now just beginning to look at the potential.

2. The increasing number of Federal, state and city agency programs in the health field, thus increasing the demand for knowledgeable people to initiate and coordinate these programs.

3. Within the Medical Center, the supervisory and management concepts are involved in a thorough re-evaluation. Again, there is an obvious need for knowledgeable people.

We could continue on looking at all facets of the health professions, ranging from the suppliers of the material to the delivery of health care, and in each of these areas identify many directions in which the Physician's Assistant might go. But rather than do this, we can summarize by saying that the same conviction which allowed us to begin the Physician's Assistant Program with so many unknowns now allows us to predict a bright future for the graduates with an equal or possibly even a greater number of unknowns.

Mr. James Mau
Administrative Director
Physician's Assistant Program
Duke University Medical Center.

A NEW PROGRAM

Child Health Assistant
(Pediatric Assistant)

This September the Bowman Gray School of Medicine of Wake Forest University will open its doors to the first class of a two year program to train competent individuals who will function under the direction of, and in close association with, a Pediatrician in providing a broader health service to children. It is estimated that a Pediatrician in practice spends 50-80% of his time caring for well children and minor illnesses.

This new worker in the health field will be trained to perform histories and physical examinations as well as visual, auditory, and developmental laboratory screening tests. A major emphasis will be placed on well children evaluation and care, management of common behavioral problems, and counseling with parents.

Matriculation requires a high school diploma and/or two years of college credits with courses in chemistry, biology, and math. Individuals with special training and experience in medicine and related fields may be given equivalency credits. Applicants must also complete and submit S.A.T., C.E.E.B., and Math Achievement level I scores. Tuition for the program will be $40 per quarter. The curriculum is divided up into quarters for the first year. The second year is a rotating internship in which the student rotates through the various clinical settings.

Courses consist of medical vocabulary and records, anatomy, physiology, pathology, medical instrumentation, pharmacology, growth and development, laboratory experience, pediatric physical examinations, disease entities, immunity and immunizations, common behavioral problems, and evaluation of the well child as well as the sick child.

The second year will be spent in the well baby clinic, newborn nurseries, pediatric wards, and outpatient clinics among other clinical areas.

Starting salary is estimated to be in the range of $7-9,000 yearly. It should be noted that the first class is to be composed of 5 or 6 women. Males will be admitted later after the school has had time to evaluate the acceptance by the public. Nurses have been excluded in an effort to recruit new personnel. [1]

Mr. E. B. Eason
Staff Writer

EMPLOYMENT OFFERS

The A.A.P.A. has the following job offers available for its membership. It should be noted that one should contact his or her program director or job counselor for specific job placement. It should also be appreciated that the job offers with their job description and/or salary are printed when available and if this data is not included with the job offer it is because we do not have this information.

Here are but a few of the job offers available at the present time:

1. Dr. Peter V. Teal, Orthopedic Surgeons, P.S.C.,
Medical Arts Center, 1230 North 30th St., Billings, Montana
59101

2. Dr. Kenneth B. Cairns,
Red Hook Neighborhood Health Center
100 Clinton St., Brooklyn, New York

3. Dr. John McHugh, Family Medical Center,
2623 Edgemont St., Rockford, Ill. 61103

4. Dr. George Franck,
Western Electric, 6701 Roswell Rd., Northeast,
Atlanta, Georgia 30328

5. Dr. Malcolm P. Tyor,
Professor of Medicine,
Chairman, Dept. of Gastroenterology,
Duke University Medical Center,
00550 Clinical Research I,
Durham, N.C. 27706

STANDING COMMITTEES APPROVED

The Board of Directors have approved standing committees for the on coming year and have elected their respective chairmen. The Board of Directors and the committee chairmen welcome any members' ideas, thoughts, and/or labor, and, you are invited to contact the respective people through the A.A.P.A. address. The committees and their chairmen are as follows:

1. Public Relations Committee,
co-chaired by Mr. Richard Scheele
and Mr. Kenneth Ferrell.

2. Registration and Certification Committee,
chaired by Mr. William Vogler.

3. Convention and Election Committee,
chaired by Mr. John McQueary.

4. Finance Committee,
chaired by Mr. Roger Whittaker.

5. Fund Raising Committee,
chaired by Mr. Nelson Myers.

6. Membership Committee,
chaired by Mr. Charles Mitchell.

7. Ethics Committee,
chaired by Mr. Kenneth Ferrell.

Members in the Association are urged to participate on the committee of his or her interest and should write the committee chairmen through the A.A.P.A., Box 2951, West Durham Station, Durham, N. C.

MEMBERSHIP OPEN

The Board of Directors have approved a new set of regulations regarding membership in the American Association of Physicians' Assistants. The membership will be open year round to new members and a ninety-day period will be open from October 1st through January 1st for re-registration of active members. Each new applicant must write for an application form to:

Mr. Charles Mitchell
Membership Committee Chairman
American Association of Physicians' Assistants
Box 2921
West Durham Station
Durham, North Carolina

The application form must be filled out completely and returned with a $5.00 processing fee to Mr. Charles Mitchell. Upon acceptance into the A.A.P.A. the new member must remit a $20.00 fee and then as an active member must remit $20.00 per year to renew his or her membership. These monies should be sent to:

Mr. Roger Whittaker
Treasurer
American Association of Physicians' Assistants
Box 2951
West Durham Station
Durham, North Carolina

If an active member fails to remit the yearly fee during the allotted time, then he or she will have to reapply for membership into the association. The benefits to active membership are always multiplying and those now available are: 1) a vote in the organization on major issues, 2) the right to voice your opinions and call special meetings with a majority vote of the association, 3) the right to attend the annual meeting, elect new officers, and enjoy the festivities, and 4) the Newsletter of A.A.P.A. published quarterly.

The association will continue with its "student membership." The student need only write for an application, be from a program approved by the A.A.P.A., and pay a $12.00 per year fee after acceptance. No processing fee is required but the student must also re-register between October 1st through January 1st each year. The benefits are, of course, fewer and are as follows: 1) the student may attend the annual meeting, 2) the student may voice his opinion on any issue but does not have the power to vote or call special meetings, and 3) the student would receive the Newsletter quarterly.

The American Association of Physicians' Assistants welcomes all qualified applicants and urges everyone to join now!

MEDI-QUIZ

1. In an untreated patient who has headache and nuchal rigidity the CSF fluid is found to contain 375 mononuclear cells; sugar is 15mg/100ml. Which of the following would be most likely to produce this clinical picture?
   (a) Meningismus
   (b) Viral meningitis
   (c) Tuberculous meningitis
   (d) Bacterial meningitis
   (e) Brain abscess
2. The adrenogenital syndrome due to adrenocortical hyperplasia can best be differentiated from that due to adrenocortical tumor by:
   (a) Determination of urinary 17-ketosteroids and pregnanotriol.
   (b) Measurement of 17-ketosteroids and pregnanetriol before and after the administration of 0.5 mg of dexamethasone every 6 hours for 3 days.
   (c) Measurement of urinary 17-ketosteroids and 17-ketogenic steroids, before and after the administration of metyrapone (Metapirone).
   (d) Surgical exploration.
   (e) Age on onset of the disorder.

EDUCATIONAL ARTICLES

DISTINGUISHING RAYNAUD'S DISEASE FROM PHENOMENON

"State of digital arteries indicates whether syndrome is disease or phenomenon"

Raynaud's syndrome should be subdivided into Raynaud's disease and Raynaud's phenomenon, depending on the state of the digital arteries.

All cases of episodic digital ischemia should be labeled Raynaud's syndrome. If the digital arteries are normal, featuring vasospasm, the case is Raynaud's phenomenon. This carries a good prognosis and the results of treatment are most satisfactory. Vasospasm may be induced by general body cooling and immersion of the hands in cold water. If digital artery disease is diagnosed, with occlusion, the case is Raynaud's disease. This syndrome can often be induced by local cold alone, indicating that sympathectomy is of little value in improving the circulatory status. Treatment is generally unsatisfactory and the long-term prognosis usually poor. Because Raynaud's disease may be associated with a number of underlying disease entities, extensive laboratory and x-ray investigation may be necessary for precise diagnosis.

Patients with Raynaud's phenomenon are at no risk from serious nutritional change which may lead to gangrene. However, in cases of Raynaud's disease, the underlying disease process is usually progressive and inspite of treatment, often irreversible.

Raynaud's phenomenon occurs more frequently in women, often first appearing at the menarche or menopause. Exposure to cold triggers the sympathetic nervous system with over activity producing the characteristic color changes. The digits usually become dead white at the tips and pass through progressive phases of cyanosis and rubor as rewarming occurs and blood flow is restored. Both hands are usually affected symmetrically, although the thumbs generally are spared due to their richer blood supply. Although minor reversible trophic changes may occur in the winter months, the hands are ordinarily completely normal between attacks. Digital artery thrombosis never occurs.

The syndrome of Raynaud's disease usually lacks the symmetry of Raynaud's phenomenon. Attacks tend to occur more frequently and at warmer temperatures.

With few exceptions, the etiology of Raynaud's phenomenon is unknown. It usually represents an exaggerated local

and general physiological response to cold acting via the sympathetic nervous system. Raynaud's disease is a feature of many disease states. In the early stages, before arterial occlusion becomes severe, some of the conditions cannot be differentiated on clinical grounds from Raynaud's phenomenon.

In all cases, treatment includes avoidance of cold, both general and local. Vasodilator drugs are helpful in cases of Raynaud's phenomenon but seldom benefit a patient with Raynaud's disease. However, in those with digital artery obstruction, symptoms usually recur. [2]

VIRUS INFECTIONS IN PATIENTS WITH MALIGNANT DISEASES

Unusual manifestations of common virus diseases have frequently been reported in malignant disease that involves the reticuloendothelial system and are thought to be owing to depression of antiviral defense factors. The effect of malignant disease itself in producing these manifestations is sometimes obscure because of the concurrent treatment (with steroids, x-ray, and/or cytotoxic drugs) which on its own can depress antiviral defense mechanisms. Indeed, a review of the literature indicates that malignant disease involving the reticuloendothelial system particularly when being treated, can convert relatively harmless virus infections into serious and sometimes fatal illnesses. For example, serious complications such as generalized vaccina gangrenosa can follow smallpox vacination and there are reports of fatal infections of measles and chickenpox. There is an increased incidence of zoster and cytomegalovirus infections in these conditions. There is also a possibility that bacterial chest disease, which is frequently associated with these diseases, is caused in the first instance by increased susceptibility to respiratory viral infections.

Further studies on viral infection in patients with malignant disease of the reticuloendothelial system, particularly if they are being treated with immunosuppressant properties, should enable clinicians to more fully appraise the dangers of such treatment and should provide valuable information on what are perhaps somewhat belated, but nevertheless highly efficient, antiviral mechanisms. [3]

FAT EMBOLISM SYNDROME

The occurrence of fat embolism as a complication of skeletal and soft tissue trauma has been of interest for more than a century. The incidence of fat embolism is relatively high and the severity of this complication with multiple injuries is not generally appreciated. Fat embolism produces a clinical syndrome with characteristic findings and pertinent laboratory results. The most essential feature of the diagnosis of fat embolism is a high index of suspicion. Recent advances in treatment of fat embolism have contributed to a decrease in morbidity and mortality.

Clinical features include the following: (1) lucid interval - few hours to four days after injury; (2) dyspnea - may be marked and accompanied by cyanosis; (3) changes in mental status - drowsiness, restlessness, confusion; (4) temperature elevation - as high as 39.5°C; (5) tachycardia - pulse rate of 140 or higher and respiratory rate of 30 or higher; (6) petechiae across root of neck, in axilla, and conjunctiva; (7) changing neurological examination - pathologic reflexes; (8) fundoscopic examination - hemorrhagic exudates.

Laboratory features include (1) lipuria - free fat in urine in 50% 3 days post injury; (2) serum lipase elevation - significant elevation for 3-7 days post-injury; (3) chest roentgenogram - typical "snowstorm" pattern of pulmonary infiltrate, serial x-rays helpful; (4) hemaglobin fall - sudden, sharp unexplained drop occurring shortly after onset of symptoms.

General therapeutic measures include maintaining airway, treating shock, administering parenteral fluids and oxygen, and immobilization. Specific treatment is directed at lowering the plasma lipid value and improving the posttraumatic micro-circulatory flow patterns. Heparin administration in small intravenous injections of 10-50 mgm. every 6 to 8 hours, exerts a chylolytic effect without risk of hemorrhage. Low molecular weight Dextran (Rheomacrodex) 500 ml. intravenously every 12 hours, improves micro-circulatory flow. The respiratory failure associated with fat embolism is best treated by mechanically assisted respiration and by the intravenous administration of cortico steroids (100 mgm. every 6 to 8 hours). With the use of heparin, low molecular weight dextran, and corticosteroids, the treatment of fat embolism has become more specific and less empiric. [4]

OUTLOOK IN CHRONIC OBSTRUCTIVE LUNG DISEASE IS GRAVE

Chronic obstructive lung disease evidently is a slowly progressive disorder beginning many years before the onset of clinical symptoms, possibly even in childhood. The disease systematically worsens, but yearly changes are relatively slight and may be evident only after long-term observation.

The forced expiratory volume in one second (FEV_1) for affected persons appears to decline an average of 75 - 80 ml. per year; at this rate the disease may progress twenty to thirty years before ventilatory impairment becomes severe enough to produce clinically significant dyspnea. Once mild chronic dyspnea develops - usually an FEV_1 between 1.5 and 2 liters - progression to severe disability may take from six to ten years. The true overall rate of decline in ventilatory function is difficult to determine for the last stages of the disease because rapid worsening, especially in patients with severe obstruction, is likely to result in death before the changes are documented.

Symptomatic relief may be obtained in many patients and appropriate treatment will prolong life for those with severe hypoxemia and cor pulmonale or with recurrent acute exacerbations. Currently available therapy usually does not prevent gradual deterioration, and prognosis for patients with symptomatic chronic obstructive lung disease is poor. Most deaths are directly attributable to the underlying lung disease or one of its complications.

A prospective study was made of 200 patients with chronic obstructive lung disease. The average decline in FEV_1 was 75 to 80 ml. per year. Overall five year mortality was 47%. With mild to moderate expiratory slowing (FEV_1 more than 1.5 liters) five year life expectancy was near normal in uncomplicated cases, but about 66% in patients with evidence of cardiac disease or tachycardia at rest. With moderately severe ventilatory impairment (FEV_1 0.75 to 1.15 liters) five year survival for uncomplicated cases was 66% but only 33% if cardiac disease, tachycardia at rest, hypercapnia, or very low pulmonary diffusing capacity was present. With very severe expiratory slowing (FEV_1 less than 0.75 liter) only 33% of patients without complications survived five years, and five-year survival was rare if any adverse conditions were present. Patients in whom the expiratory volume fell more rapidly than 50 ml. per year had a less favorable prognosis than those in whom physiological tests were more stable. [5]

VARIABLES OF SECOND-SOUND HEART SPLITTING

The second heart sound should be evaluated with the patient both upright and supine before a judgement is made concerning the existence of an abnormal splitting pattern. Phonocardiograms were obtained during normal respiration in both sitting and supine positions in 116 healthy children and adolescents for assessment of varying factors that might influence second-sound splitting. Greater variation in splitting occurred while sitting than while supine in 99 subjects; in 17, the greater variation was in the supine position. The splitting pattern was relatively unaffected by heart rate, sex, age, weight, or height; 17 had fixed splitting - defined as less than a 10 msec. variation during normal breathing - in either but not both positions. [6]

MEDI-QUIZ ANSWERS

1.) C [7]

2.) B [8]

RECOMMENDED READING

1. Formation, Transport, Metabolism and Excretion of Bilirubin. By Gartner, L.M. and Arias, I.M. New England Journal of Medicine Vol. 280, No. 24, pages 1339 - 1345.

2. Sodium Metabolism. By Earley, L.E. and Daugharty, T. M.. New England Journal of Medicine Vol. 281, No. 2, page 72.

3. Pediatric Seizure Disorders: Post Graduate Medicine Vol. 46 No. 1. July, 1969.

4. Juvenile Rheumatoid Arthritis. By John L. Calabro, M.D. GP Vol. XI. No. I. July, 1969.

EDITORIAL

THE DUKE PHYSICIANS' ASSISTANT PROGRAM

Since the realization of the need for a Physicians' Assistant (P.A.) by Dr. Eugene A. Stead, Jr. in 1964 to the graduation of the first class in 1967, the Duke Physicians' Assistant Program has made many improvements. The Duke program has remained unsurpassed even with the addition of new programs - and only through much critizism and hard work.

While there has been unwarranted critizism from outside the Duke Medical Complex - that from within has been entirely constructive. The critizisms that stemmed from within were at first denied by the program's administration, but they were later realized by change. The main changes were 1) the addition of better classes, 2) better scheduling of classes, 3) a larger administration, and 4) an administration maturing into professionalism. The changes did indeed come but more must materialize.

There are many improvements to be made. We should not forget the unorganized classes with tardy and unorganized instructors. The curving of test scores should be abolished since standards have been established by preceding classes. The second year (15 months), the most important phase of the program is now the poorest. During the eight week rotations medical educators should be responsible for the student learning specific tasks and data. At the present time a student may go through an entire rotation without any formal supervision. It is nice to say that "it's up to the student," but that is not the way any educational process works entirely. A Bachelor of Science Degree is necessary and would be more preferred and acceptable if it came from Duke University. One hears of subspecialty training for Physicians' Assistants in the very near future (i.e., this year), but I believe we should perfect what we have before we overextend ourselves in this area. I do not want to degrade the program, but these are a few areas which I feel need to be developed.

In retrospect, I suppose it is not fair to criticize a program that is constantly changing. Duke is undoubtedly producing top flight Physicians' Assistants - professionals, a colleague to stand beside the physician in the practice of medicine. And I sincerely believe that the Duke Physicians' Assistant Program is without a doubt the best and most progressive program in the country and a program that will in all probability never be surpassed.

THE EDITOR'S NOTES

New P.A. programs starting in the near future: University of Alabama, Stanford Medical Center and Oklahoma University.

Another program called Medex at the University of Washington received a $494,000 federal grant but, unfortunately, will probably not produce Physician's Assistants as we know them today. To date there are six operational "Physician's Assistant" programs and many "paramedical programs" trying to ride in on the P.A.'s success. The Duke P.A. program will turn B.S. program within the year. After returning from private practice, I am of the firm conviction that a P.A. is worth at least $10,000, if not, $12,000 starting in private practice, that is a P.A. trained in the Duke tradition. Two hard working A.A.P.A. board members: Mr. James Broach and Mr. Carl Fasser! An outstanding A.A.P.A. member who presented our association to the North Carolina State Medical Society - Mr. Richard J. Scheele! I hope everyone read the A.M.A. News dated December 1, 1969, and their articles on the Physician's Assistant-unjust and slanted articles based on theory rather than on fact. This Newsletter should have been to you in November 1969 - well we've switched printers and promise that that will never happen again. Next issue, an article written especially for the A.A.P.A. by Senator Jacob K. Javits.

As usual, I must state that the preceding editorials are my opinions only and are not necessarily those of the American Association of Physician's Assistants.

Thomas R. Godkins
EDITOR

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