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ABSTRACT

Both the project report and the resultant role delineation for entry level physician assistants are included in this first volume of a two-volume report of a study which had two major purposes: (1) To further develop a role delineation for the assistant to the primary care physician and (2) to provide an educational resource for those involved in training physician assistants. An introductory section describes the activities: Scope of work, methodology, people involved, list of physician assistant programs surveyed, and the two products (role delineation and curriculum resource guide.) A second section considers in more detail the methodology, future work, and components of role delineation. The last half of the document consists of the role delineation which was developed: the minimum basic major and specific responsibilities and competencies for the entry level physician assistant. (Volume II is the curriculum resource guide which was developed based on the role delineation.) (LAS)

FINAL REPORT

CURRICULUM RESOURCE DOCUMENT

Prepared for

Health Resources Administration
Department of Health, Education, and Welfare

Under

Contract HRA 231-75-0209

December 24, 1976

AMERICAN ACADEMY OF PHYSICIANS' ASSISTANTS
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VOLUME I

ROLE DELINEATION

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* These materials were not developed under this contract.

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ACKNOWLEDGEMENTS

This report could not have been carried out without the input, support and active participation of many people. The members of the Working Committee spent many long and tedious hours between meetings developing and evaluating the materials developed under this contract. The project's consultants also spent long hours developing and reviewing many of the educational materials found in this report as well as providing support and direction to the project staff.

Dr. Margaret A. Wilson, the Health Resources Administration Project Officer was particularly helpful and supportive. She provided much of the direction and advice necessary for carrying out this project.

The project staff would like to thank the members of the Association of Physician Assistant Programs for not only providing their curriculae, but for their continual enthusiasm and support of this work.

The project staff also acknowledges the special contribution of Ms. Susan Herre in helping prepare the final report.

Finally, a special acknowledgement is made to the physician assistant, whose dedication to the profession helps make this work worthwhile.

Donald W. Fisher, Ph.D.
Judy A. Light

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I. INTRODUCTION

In April, 1975, the Government Accounting Office (GAO) reported to the Congress on the "Progress and Problems in Training and Use of Assistants to Primary Care Physicians." One of their recommendations identified a need to study various physician extender training programs to determine which methods: (1) are best suited for producing physician extenders in the most efficient and economical manner; and (2) best meet the needs of the health care delivery system. The Department of Health, Education, and Welfare's response indicated their desire to evaluate the competency of each program's graduates rather than identify a single standard curriculum for physician extenders.

> We have some difficulty with the recommendation to the extent that it suggests that there should be a single standard curriculum for physician extenders. We would prefer to recognize the variety of academic and experiential backgrounds possessed by persons who enter physician extender training, as well as the different kinds of health delivery settings in which these persons function, and to concontrate evaluation efforts on determining whether the final product is reasonably standard and whether it prepares trainees with the flexibility to carry out the varied functions and responsibilities agreed to be essential for full performance. (GAO, 1975, p. 11)

HEW's concern for the competency of program graduates has been apparent in its support of competency examinations for physician assistants and the establishment of the National Commission on Certification of Physician's Assistants. In the spring of 1975, a contract (HRA 231-75-0209) was awarded to the American Academy of Physicians' Assistants in cooperation with the Association of Physician Assistant

Programs. The proposal for the Curriculum Resource Document resulted from discussions by the Curriculum and Testing Committee of the Association of Physician Assistant Programs.

A. Purpose

The two major purposes of the DHEW contract, a Curriculum Resource Document for Assistants to Primary Care Physicians, were to:

1) further develop a role delineation for the Assistant to the Primary Care Physician; and

2) provide an educational resource for those involved in training physician assistants.

It was not the purpose of this contract to define <u>all</u> the tasks and responsibilities of physician assistants nor to define a <u>total definitive</u> curriculum for training physician assistants. Rather, the purposes of the role delineation were to obtain agreement on the varied competencies and responsibilities essential for the full performance of the practitioner and to provide information to training programs to assist in developing curricula.

B. Scope of Work

In pursuance of these goals, the American Academy of Physicians' Assistants (AAPA) in cooperation with the Association of Physician Assistants Programs undertook to:

1) Establish a Working Committee to help carry out the work of the contract. Members of this committee were to include representatives with the following backgrounds:

   a) practicing physician assistants;
   b) practicing physicians who employ physician assistants;
   c) faculty members of physician assistant programs, who themselves are physician assistants; and
   d) other faculty members of physician assistant programs.

   The committee also included a representative of the National Commission on Certification of Physician's Assistants, a representative of the American Medical Association Council on Medical Education, and an observer from the Health Resources Administration, Bureau of Health Manpower.

2) Develop a role delineation for the Assistant to the Primary Care Physician to include:

   a) an identification of the knowledge and skill competencies essential to practice at the entry level; and
   b) a listing of the characteristics (attribute expressions and values) essential to practice at the entry level.

3) Develop a Curriculum Resource Document to include:

   a) a sampling of behavioral objectives for selected knowledge and skill competencies and specific attribute expressions and values;
   b) a description of learning opportunities specific to attainment of selected competency and attribute behaviors;
   c) a description of teaching strategies appropriate to helping the learner attain selected competency and attribute objectives; and
   d) a description of approaches to evaluation appropriate for teacher use in the appraisal of the learner's possession of competencies.

C. Methodology

In order to meet the objectives of the project and implement the specified Scope of Work, the AAPA project staff employed three major methods:

1) Members of the Association of Physician Assistant Programs were asked to supply the project staff with the following information:

   a) the objectives of their total program;
   b) the bibliography used in each course;
   c) the objectives of each course;
   d) any materials developed by the program;
   e) a list of courses required, including the number of required hours in class work, in the laboratory, and in clinical settings;
   f) a description of the approaches used in training physician assistants (e.g., any attempts at individualizing instruction); and
   g) any other information about their program that they felt might be useful.

2) The Working Committee, as a panel of experts, was asked to modify the Roles, Functions, and Responsibilities of the Assistant to the Primary Care Physician (1971) as produced by the National Board of Medical Examiners in delineating the role of the physician assistant.

3) Educational consultants provided expert knowledge to the Working Committee and project staff in the development of a sampling of behavioral objectives, teaching strategies, and methods for appraising student performance.

D. People

The project staff was responsible for developing the methodology for carrying out the specified scope of work, conducting all committee meetings, eliciting information from the committee members and educational consultants, and writing

the final report. The Project Director was Donald W. Fisher, Ph.D., Executive Director, the American Academy of Physicians' Assistants, and the Association of Physician Assistant Programs. The Associate Project Director was Judy A. Light.

The major activities of the Working Committee involved developing the role delineation for the Assistant to the Primary Care Physician and developing a sample of behavioral objectives, teaching strategies, learning opportunities, and methods for appraising the learner. The members of the committee were selected to include persons with diverse experience and backgrounds concerning the physician assistant concept. The diversity of the committee resulted in the development of a role delineation which represents many compromises; it does not represent the thinking of any one individual but rather represents a consensus.

The members of the Working Committee were:

Earl V. Echard, P.A.-C.
Lincoln Community Health Center
Durham, North Carolina

Carl E. Fasser, P.A.-C.
Education Coordinator
Physician's Assistant Program
Center for Allied Health Manpower Development
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Gayle C. Spears, P.A.-C.
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William D. Stanhope, P.A.
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Hal T. Wilson, M.D., M.P.H.*
Medical Director
Physician's Assistant Program
Division of Allied Health Programs
Bowman Gray School of Medicine
Wake Forest University
Winston-Salem, North Carolina

Henry R. Datelle, Ed.D., Assistant Director, represented the National Commission on Certification of Physician's Assistants.

* Dr. Hal Wilson is presently Director, Clinical Associate Program, College of Allied Health Professions, University of Kentucky, Lexington, Kentucky. Further, Dr. Wilson has requested that it be noted that he is not in complete accordance with the final report.

L. M. Detmer, M.H.A., Assistant Director, Department of Allied Health Evaluation, represented the American Medical Association.

Robert M. Conant, Ph.D., Chief, Manpower Utilization Branch, observed on behalf of the Division of Associated Health Professions, Bureau of Health Manpower, Health Resources Administration.

In addition to the Working Committee, the AAPA project staff employed several educational specialists to provide consultation to the project staff. Educational consultants included:

Barbara J. Andrew, Ph.D.
Director
Department of Research and Evaluation
National Board of Medical Examiners
Philadelphia, Pennsylvania

Judy L. De Mers, R.N., M.Ed.*
Associate for Curriculum Development
MEDEX Northwest
Seattle, Washington

Carl E. Fasser, P.A.-C.**
Education Coordinator
Physician's Assistant Program
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Department of Community Health
Baylor College of Medicine
Houston, Texas

Harriet G. Gales, M.A.
Director
Physician's Assistant Program
Mercy College
Detroit, Michigan

---

* Ms. De Mers is presently Director, Family Nurse Practitioner Program, Department of Community Medicine, University of North Dakota Medical School, Grand Forks, North Dakota.

** Mr. Fasser served as both a member of the Working Committee and as an educational consultant.

Stephen C. Gladhart, M.A.
Assistant Program Director for Administration and Education
Physician's Assistant Program
Wichita State University
Wichita, Kansas

Suzanne B. Greenberg, M.S.
Director
Physician Assistant Program
Northeastern University
Boston, Massachusetts

C. M. Lindvall, Ed.D.
Professor
Department of Educational Research
Learning Research and Development Center
University of Pittsburgh
Pittsburgh, Pennsylvania

Larry J. Reynolds, Ph.D.*
Coordinator for Curriculum Planning and Evaluation
Utah MEDEX Project
Department of Family and Community Medicine
University of Utah College of Medicine
Salt Lake City, Utah

E. Association of Physician Assistant Programs

The following is a list of the members of the Association of Physician Assistant Programs, who were to supply information concerning their curricula:

Surgeon's Assistant Program
University of Alabama Medical Center
Birmingham, Alabama

* Dr. Reynolds is currently on special assignment for the Division of Family Practice, University of Utah College of Medicine.

California MEDEX
Charles R. Drew Postgraduate Medical School
Los Angeles, California

Family Nurse Practitioner Program
University of California at Davis
School of Medicine
Department of Family Practice
Davis, California

*Primary Care Associate Program
Stanford University Medical Center
Stanford, California

Child Health Associate Program
University of Colorado Medical Center
Denver, Colorado

Physician's Associate Program
Yale University School of Medicine
New Haven, Connecticut

MEDEX Physician Assistant Program
Howard University College of Allied Health
Washington, D.C.

Physician's Assistant Program
George Washington University Medical Center
Washington, D.C.

Physician Assistant Program
J. Hillis Miller Health Center
Gainesville, Florida

Physician's Assistant Program
Medical College of Georgia
Augusta, Georgia

Physician Associate Program
Emory University School of Medicine
Atlanta, Georgia

* Became member of the Association of Physician Assistant Programs in 1976.

MEDEX/Pacific
University of Hawaii School of Medicine
Honolulu, Hawaii

Physician's Assistant Program
Indiana University School of Medicine
Fort Wayne, Indiana

Physician's Assistant Program
University of Iowa College of Medicine
Iowa City, Iowa

Physician's Assistant Program
Wichita State University
Wichita, Kansas

Health Associate Program
Johns Hopkins University
School of Health Sciences
Baltimore, Maryland

Physician's Assistant Program
Essex Community College
Baltimore, Maryland

Physician Assistant Program
Northeastern University
Boston, Massachusetts

Physician's Assistant Program
Mercy College
Detroit, Michigan

Physician's Assistant Program
Western Michigan University
Kalamazoo, Michigan

Physician Assistant Training Program
United States Medical Center for Federal Prisoners
Springfield, Missouri

St. Louis Inter-Institutional Physician's Assistant Program
St. Louis, Missouri

Physician's Assistant Program
University of Nebraska Medical Center
Omaha, Nebraska

Community Health Medic Program
Gallup, New Mexico

Albany-Hudson Valley Physician's Associate Program
Albany Medical College
Albany, New York

*Physician's Assistant Program
Long Island University
Brooklyn Cumberland Medical Center
Brooklyn, New York

*Physician's Assistant Program
The New School/Harlem Hospital Center
New York, New York

Physician Associate Program
S.U.N.Y. at Stony Brook
School of Allied Health Professions
Stony Brook, New York

Physician's Associate Program
Touro College
New York, New York

Physician's Assistant Program
Bowman Gray School of Medicine
Winston-Salem, North Carolina

Physician's Associate Program
Duke University Medical Center
Durham, North Carolina

Family Nurse Practitioners Program
Minot State College Campus
Minot, North Dakota

Physician's Assistant Program
Cleveland Clinic
Cleveland, Ohio

Physician's Assistant Program
Cuyahoga Community College -- Western Campus
Parma, Ohio

Physician's Assistant Program
Kettering College of Medical Arts
Kettering, Ohio

*Physician's Assistant Program
Lake Erie College
Painesville, Ohio

Primary Care Physician Assistant and Surgical Assistant Program
Cincinnati Technical College
Cincinnati, Ohio

Urologic Physician's Assistant Program
University of Cincinnati Medical Center
Cincinnati, Ohio

Physician Associate Program
University of Oklahoma
Oklahoma City, Oklahoma

MEDEX Pennsylvania Program
The Milton S. Hershey Medical Center
Pennsylvania State University
Hershey, Pennsylvania

Physician Assistant Program
Hahnemann Medical College
Philadelphia, Pennsylvania

Physician Assistant (MEDEX) Program
Medical University of South Carolina
Charleston, South Carolina

Physician's Assistant Program
Baylor College of Medicine
Houston, Texas

Physician's Assistant Program
Department of Health Care Sciences
School of Allied Health Sciences
University of Texas Medical Branch
Galveston, Texas

Physician's Assistant Program
University of Texas
Health Science Center at Dallas
Dallas, Texas

USAF/USN Physician Assistant Program
School of Health Care Sciences
Sheppard Air Force Base
Wichita, Texas

Utah MEDEX Project
University of Utah Medical Center
Salt Lake City, Utah

MEDEX Northwest Program
Seattle, Washington

Physician's Assistant Program
Alderson-Broaddus College
Philippi, West Virginia

Physician's Assistant Program
Marshfield Medical Foundation
Marshfield, Wisconsin

F. Products

Role Delineation

A major product of this contract has been to define the role delineation for the Assistant to the Primary Care Physician. The purpose of a role delineation is to present in a clear manner a description of the responsibilities and competencies that

comprise the duties of the practitioner of a specific profession. In no way does or should a role delineation impose restrictions on an individual practitioner; instead it provides a description of the basic duties and responsibilities all practitioners are expected to carry out as a physician assistant. The term "minimum basic" is often used to describe the responsibilities stated in a role delineation, where minimum basic means the smallest scope and lowest level of responsibilities essential for providing quality care. Role delineations are not meant to prevent a practitioner from performing any task, only to describe those minimum basic tasks in which all physician assistants are expected to demonstrate competency.

Curriculum Resource Guide

The purpose of the other major product of this contract, a Curriculum Resource Guide, is to provide guidance to program developers for designing educational programs. This guide should be helpful in several ways, including:

1) a demonstration of how to use the role delineation to develop curricula, including a sampling of behavioral objectives, a description of possible teaching strategies and approaches to appraising the learner's competency;

2) a reference for sources describing the components of curriculum development activities, evaluation activities and discussions of the physician assistant concept; and

3) an introductory exchange of some innovative approaches presently used in educating physician assistants.

II. ROLE DELINEATION FOR THE ENTRY LEVEL PRACTITIONER

As previously stated, the main purpose of a role delineation is to present in a lucid manner a description of the responsibilities and competencies that comprise the duties of the practitioner of a specific profession. In order to more fully understand the developed role delineation, some discussion about the components of a role delineation, the methodology used, and the plans for future work is necessary.

A. Components of a Role Delineation

A role delineation consists of two components: major and specific responsibilities. The purpose of each component is to define the role of the practitioner in progressively more detail. The reason for providing this detail is to insure that these minimum basic competencies are not subject to multiple interpretations.

Major responsibilities are usually the first component to be identified. These are broad areas of responsibilities, each conveying one major activity. When taken together they provide a general overview of the responsibilities of the practitioner within the profession. They are always stated in terms of what the practitioner does.

The next component to be identified is the specific responsibilities. These are more detailed statements, also stated as performances of the practitioner, that describe the execution of each major responsibility. When taken together these provide a more detailed overview of the responsibilities of the practitioner.

Although the specific responsibilities provide a concise description of the responsibilities of the practitioner, they are usually not sufficiently detailed to be useful in curriculum development and evaluation activities. When necessary, a third and fourth level of performance statements are specified in order to provide the detail necessary for accomplishing these activities.

Finally, in describing the components of a role delineation, it is neither practical nor useful to include all the possible activities of all practitioners. As such, the intent of a role delineation is not to impose upper boundaries but rather to identify only those abilities that are absolutely essential for practicing as a physician assistant.

B. Methodology

The components of the Role Delineation for the Assistant to the Primary Care Physician were developed by the members of the Working Committee. The Working Committee members included physicians who employ physician assistants, practicing physician assistants, physician assistants who help train physician assistants, and physicians who help train physician assistants. Representatives of the American Medical Association Council on Medical Education, the National Commission on Certification of Physician's Assistants, and the Health Resources Administration Bureau of Health Manpower also participated.

The committee members were provided with the National Board of Medical Examiner's Roles, Functions, and Responsibilities of the Assistant to the Primary Care Physician (1971) as well as all available pertinent role description information from the members of the Association of Physician Assistant Programs.

Structured group decision making techniques (e.g., Nominal Group Technique), small group discussions, checklists, modified Delphi Technique, and simulations were used to generate the Role Delineation for the Assistant to the Primary Care Physician.

C. Future Work

Verification of Role Delineation

Although the individual members of the Working Committee were selected according to their background and experience in the physician assistant profession, the role delineation they defined represents to some degree their personal views.

In order to insure that this role delineation is, in fact, an appropriate definition of the practitioner's competencies at entry level, careful comparisons have to be made between the perceptions of these "experts" who are primarily involved in training physician assistants and the actual practice and utilization of physician assistants. During the next three years, another panel of experts will be involved in verifying this role delineation.

Position Classification

During the development of the Role Delineation, a concern was expressed that the role being defined may not be appropriate for all physician assistants; as the role may vary for some physician assistants according to years in practice, experience, geographic location, or type of practice and setting. If this is indeed true, there would be more than one kind of physician assistant, where each kind of physician assistant's role would consist of different and distinct responsibilities and competencies.

Therefore, the Role Delineation for the Assistant to the Primary Care Physician, as presented in this document, describes the competencies and responsibilities of what has been defined as the "entry level" practitioner. The term "entry level" has been assigned to identify this Role Delineation because it is usually this position that is used as the reference point from which all other such positions are developed.

Although it is not within the immediate scope of this present effort of developing the Role Delineation to define other position classifications, it seems useful to diverge slightly and discuss some of the theory behind position classification. This should help to clarify what is meant by the term "entry level practitioner," and to insure that the Role Delineation is understandable and useful.

The American Academy of Physicians' Assistants has secured funding in order to investigate whether or not multiple position classifications exist within the physician assistant profession. It is not known which, if any, are appropriate for

physician assistants, and, in fact, there may be only one kind of physician assistant.

It is perhaps easiest to understand position classification by explaining why the term "entry level" is used to describe the position that is the reference point for identifying other ones. The term "entry level" is used in role delineation to describe the most basic position in a profession. If another distinct level is found to exist, then this is referred to as an "advanced level." The establishment of criteria for defining different position classifications, entry and advanced positions, is the responsibility of the profession.

Although the terms "entry" and "advanced" bring to mind "time" as a major determinant of the differences in position, this is not an appropriate or acceptable criterion. Neither is education a satisfactory means for distinguishing between an advanced position versus an entry position of a profession. The main criterion for determining whether an individual is at an advanced or entry level in a profession involves the actual activities expected of the practitioner; that is the specific competencies and responsibilities that are carried out by the practitioner in a specific position. In other words, the tasks performed on-the-job differentiate position level, not the qualifications of the individual practitioner (e.g., years of experience, education). It remains for the profession to decide which responsibilities distinguish advanced level and entry level job performance.

The purpose of the American Academy of Physicians' Assistants recently started contract (HRA 231-76-0053) is to investigate the feasibility of levels other

than entry level existing within the physician assistant profession and to establish criteria and appropriate role delineations for other position classifications. (The completion date for this contract is June, 1979.) The proposed activities of this contract should not imply that such other position classifications do exist or that practitioners presently exist to fill any level other than entry level generalist.

III. ROLE DELINEATION FOR THE ASSISTANT TO THE PRIMARY CARE PHYSICIAN

The term "physician assistant" has been used generically to describe a health professional, qualified by academic and clinical training, who carries out tasks ordinarily performed by a physician. This health practitioner works under the direction, supervision, and responsibility of a qualified licensed physician to extend the physician's capabilities in the diagnostic and therapeutic management of patients.

Assistants to the Primary Care Physician perform many medical tasks that do not require the extensive knowledge and skills of a physician (GAO, 1975). Physicians who employ physician assistants are able to spend more time with complex patient problems which require their time and judgement while patients with less complex health* problems are cared for by the physician assistant with physician supervision.

Physician Assistant

The National Academy of Sciences defines the physician assistant as one who:

> ...is capable of approaching the patient, collecting historical and physical data, organizing these data, and presenting them in such a

* Health, as used in this document, includes both preventive and interventive patient care.

way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic steps. He is also capable of assisting the physician by performing diagnostic or therapeutic procedures and coordinating the roles of other, more technical assistants. While he functions under the general supervision and responsibility of the physician, he might, under special circumstances and under defined rules, perform without the immediate surveillance of the physician. He is thus distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgement. (1970)

An Assistant to the Primary Care Physician is trained to care for patients of different ages and sexes. He/she is expected to engage in patient care in a variety of settings such as clinics, hospitals, group practices, and physician offices.

Primary Care Physician

The following statements express the concept of the Primary Care Physician and primary care.

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.*

* Adopted by the American Medical Association's House of Delegates, November, 1972.

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.*

Primary Care**

The following definition has been adopted by the American Academy of Family Physicians.

Primary care is a type of medical care delivery which emphasizes first contact care and assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. It is personal care involving a unique interaction and communication between the patient and the physician. It is comprehensive in scope and includes the overall coordination of the care of the patient's health problems, be they biological, behavioral or social. The appropriate use of consultants and community resources is an important part of effective primary care.

Decision Maker

One of the first major issues addressed in discerning the role of the Assistant to the Primary Care Physician centers around the physician assistant's role as a data gatherer and/or a decision maker. "The assistant to the primary care physician will

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* Adopted from a meeting of the Joint Review Committee on Educational Programs for the Assistant to the Primary Care Physician, October, 1972.

** A more detailed description of primary care can be found in Appendix A.

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." (AMA, p. 12.) It had also become apparent that the "education and training of individuals, who will be able to carry out under the supervision those portions of primary care that do not require a physician's capabilities, may require judgemental decisions." (NBME, p. 17.) For these reasons, the committee agreed that the role should reflect the decision making responsibilities of the physician assistant.

Supervision

The Assistant to the Primary Care Physician functions under the responsible supervision of a licensed physician. Because this requirement of supervision is so basic and essential to the performance of a physician assistant, it is not stated within the Role Delineation. This is not to be interpreted as an unimportant aspect of the physician assistant's role, but as such an essential component in describing the role and function of the physician assistant as to be meaningless to continually repeat it.

Even though a physician assistant practices under responsible physician supervision, their role is actually one of interdependency. This interdependency mandates that physician assistants be able to demonstrate a high degree of competency.

Responsibilities Unique to the Primary Care Physician

In attempting to discern the role delineation for the physician assistant, an effort was made to define those tasks which are solely the responsibility of the supervising physician. These responsibilities include the following:

1) to review, organize; synthesize and interpret a broad range of clinical cues leading to the diagnosis and management of acute, severe, chronic, and obscure physical and psychosocial conditions;

2) to establish and monitor the standards of care provided to his/her patients and to selectively incorporate changes capable of enhancing the level of care being provided;

3) the economic aspects of patient services rendered such as determination of basic charges, expansion of practice, length of hospital stay, use of diagnostic resources, referral, etc.;

4) in consultation with other professionals, making ethical decisions relating to the life and death of a patient;

5) medico-legal authority for delegating functions to the physician's assistant as well as being ultimately responsible for his/her actions;

6) to demonstrate his/her confidence in the physician's assistant employed to his/her patients; and

7) to prescribe controlled substances as identified by the Drug Enforcement Administration.

Role, Function, and Responsibilities

There have been previous attempts to define the role, function, and responsibilities of the physician assistant, In 1972 the National Board of Medical Examiners, with both federal and private assistance, in assuming the responsibility for developing a national certification examination for the Assistant to the Primary Care Physician, defined four major functions "the Assistant to the Primary Care Physician should definitely be skilled in performing: data gathering, data analysis, medical and health care procedures, and management and therapy." Extensive lists were developed for each of these functions defining the specific activities of the practitioner. These lists were then used as the basis for developing a proficiency examination that is presently used to certify physician assistants.

There have been several studies or task inventories carried out to develop similar descriptions of tasks physician assistants can perform, should perform, and might perform. Until now, there has not been developed a "role delineation" for physician assistants; a document which describes coherently and cohesively the abilities and attributes of the physician assistant. Although it has been stated that "the ultimate role of the Assistant to the Primary Care Physician cannot be rigidly defined because of variations in practice requirements due to geographic, economic, and sociologic factors," (AMA, p. 12), the minimum basic responsibilities and competencies of the entry level physician assistant can be established.

It would be a difficult task to attempt to describe all those activities that all members of a profession can carry out. Fortunately, this is not the task of a role delineation. Instead, the task is to define the major and specific responsibilities of the profession. Included in this must be a definition of minimum basic skills in which all physician assistants are competent. (The term "minimum basic" is used to imply the lower limits of skills all physician assistants will have, rather than the upper limits.) The specific training each individual has, whether formal or informal, will provide him/her with different and unique skills. The abilities specified in this Role Delineation represent the skills which must be common to Assistants to the Primary Care Physician.

The Role Delineation of the physician assistant has been developed with the following concepts present:

1) A physician assistant functions under the responsible supervision of a licensed physician. This is not specifically stated in the Role Delineation because it is inherent to the profession.

2) The Role Delineation describes the competencies of the physician assistant. It is only through an outside criterion, such as a proficiency examination, that one can ascertain competency of the individual physician assistant.

3) The Role Delineation is for the Assistant to the Primary Care Physician.

4) The Role Delineation refers to the entry level practitioner.

Role delineations are written to serve several functions, including:

a) a basis for developing instruments for evaluating a professional;

b) a guide to programs in developing formal educational experiences;

c) a guide to students preparing for a career;

d) a guide for developing Continuing Medical Education activities; and

e) a guide to the practitioner in self-assessing his/her own competencies.

It is our intent that this Role Delineation be useful in serving some, if not all, of these functions. In the second part of the document, the Role Delineation has been used to help develop a Curriculum Resource Guide to help programs in developing formal educational experiences for the physician assistant. This Role Delineation has also been developed with the idea that as the profession grows and changes, modifications can and will be made.

Major Responsibilities

Entry Level Physician Assistant

I. Establish Health Status Data Base

II. Analyze Data Base to Formulate Management Plan.

III. Develop/Formulate Health Management Plan.

IV. Implement and Monitor Health Management Plan.

V. Demonstrate Evidence of Attributes Essential to a Professional.

VI. Refer Patients as Necessary.

VII. Prepare and Carry Out Strategies to Promote Acceptance of the Role Within the Professional/Patient Community.

VIII. Maintain Competency Through Continuing Medical Education.

Major and Specific Responsibilities

I. Establish Health Status Data Base.

A. Elicit a pertinent medical and psychosocial history.
B. Perform a physical examination as pertinent.
C. Order and/or perform diagnostic tests.
D. Record and transmit findings.

II. Analyze Data Base to Formulate Management Plan.

A. Differentiate between normal and abnormal (including variations of normal) information contained in the data base.
B. Develop diagnostic impressions based upon data obtained.
C. Order more definitive tests.
D. Establish preliminary diagnosis of common primary care problems with physician guidance.

III. Develop/Formulate Health Management Plan.

A. Confer with patient.
B. Confer with supervising physician as appropriate.
C. Confer with patient's family as appropriate.
D. Consult other professionals as appropriate.
E. Use community resources as appropriate.

IV. Implement and Monitor Health Management Plan.

A. Apply established therapeutic practices to patient's problems.
B. Implement management plan.
C. Perform general preventive/screening/prenatal care.

V. Demonstrate Evidence of Attributes Essential to a Professional.

A. Know and accept that the role of the physician assistant is limited.
B. Establish effective interpersonal relationships with patients, professionals, and others.
C. Maintain attributes and express attitudes essential to the role of a professional.
D. Resist compromises in the practice of medicine when conflicting with personal ethics.

VI. Refer Patients as Necessary.

A. Refer patients with problems beyond one's professional competencies to appropriate sources of care.
B. Maintain relationship with patients referred.

VII. Prepare and Carry Out Strategies to Promote Acceptance of the Role Within the Professional/Patient Community.

A. Explain role by actions and words to others.
B. Display sensitivity to the partial overlapping and possible sharing of responsibilities with other health professionals.
C. Use (formal and informal conflict resolution) techniques including adjusting activities, fostering improved working relationships, helping behavior.
D. Transmit reference materials to relevant professionals concerning physician assistant functions and utilization.
E. Assess within the work group the behavior of individuals and group actions to facilitate problem solving or prevent problems from arising.
F. Know and implement strategies useful in gaining acceptance of the role within the community.

VIII. Maintain Competency Through Continuing Medical Education.

A. Engage in periodic review of professional skills (self-assessment).
B. Devise program of CME activities based upon perceived needs.
C. Acquire knowledge and skills essential to incorporating into practice proven new evaluation/treatment modalities.

ROLE DELINEATION*

Physician Assistant

Entry Level

As previously stated, this Role Delineation represents the minimum basic major and specific responsibilities and competencies for the entry level practitioner. Although the relationship between the supervising physician and the physician assistant is not explicitly stated through this document, it was developed with the understanding that the physician assistant would carry out only those activities explicitly delegated to him/her by the supervising physician.

I. Establish Health Status Data Base

A. Elicit pertinent medical and psycho-social history

1. Establish a profile of patient

a. Describe patient to include:

1. Age
2. Sex
3. Race
4. Domestic state
5. Occupation
6. Education
7. Disability, if any

2. Elicit historical information in the following areas:

a. Chief complaint

1. Identify primary cause for seeking help

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* This Role Delineation is currently being verified by the American Academy of Physicians' Assistants under DHEW contract HRA 231-76-0053 to be completed June, 1979.

b. History of present illness

1. Obtain characteristics of present complaint with respect to chronology, location, factors affecting complaint, and associated symptoms
2. Identify other symptoms of the system(s) involved
3. Obtain details of all other symptoms related to present illness in time

c. Past medical history

1. Obtain dates and nature of past medical and psychiatric illnesses, surgical procedures, and injuries (places, providers where needed)
2. Obtain history of allergies, immunizations, and medications
3. Identify any past problems related to present illness
4. Obtain relevant information about pregnancy, labor, delivery, and neonate
5. Obtain history about growth and development of children

d. Family history

1. Obtain health state of parents
2. Obtain health state of siblings
3. Obtain health state of other family members in regard to presence of congenital health problems or presence of inherited health problems

e. Social history, including health risk factors and current life situation

f. Review of body systems

1. Ascertain presence or absence of recent symptoms involving each system
2. Obtain detailed data (as in present illness) with respect to each symptom currently or recently present in each system
3. Determine any changes in present illness as related to other data above

3. Adapt suitable interviewing style in order to:

a. Enhance communication
b. Elicit valid information
c. Clarify clues to other history data

d. Ascertain patient's understanding of the history

4. Formulate tentative diagnostic impressions as a part of data gathering:

   a. Perform careful telephone interviews
   b. Review patient's past health records
   c. Inform physician of tentative problem list
   d. Formulate a view as to prognostic significance of each tentatively defined problem

B. Perform a physical examination as pertinent

1. Modify physical examination for the following:

   a. Comprehensive physical examination
   b. Problem specific physical examination
   c. Follow-up physical examination
   d. Age of patient
   e. Physical condition of patient

2. Observe patient's general appearance and behavior

3. Determine patient's mental status (i.e., level of consciousness, orientation)

4. Measure as pertinent:

   a. Height and weight
   b. Blood pressure
   c. Pulse rate (apical and/or peripheral)
   d. Temperature (oral and/or rectal)
   e. Respiratory rate

5. Examine skin, hair, and nails

6. Examine head and neck

   a. Size
   b. Range of motion
   c. Lymph nodes
   d. Thyroid

7. Examine eyes

a. Externally (i.e., conjunctiva, lids, extraocular muscles, pupillary reaction, peripheral vision, and acuity)
b. Internally (i.e., anterior chamber, iris, lens, posterior chamber, and retina)

8. Examine ears

a. Observe canals, tympanic membranes
b. Test hearing acuity (grossly)

9. Examine mucous membranes of nose/throat for inflammation, lesions, pallor

10. Examine gums and teeth, e.g., for gingivitis or caries

11. Examine mouth and pharynx for lesions, sores, leukoplakia

12. Examine heart and vessels

a. Inspect precordial area for PMI
b. Palpate precordial area for heaves, lifts, or thrills
c. Auscultate heart to detect abnormal sounds, i.e., irregularities, murmurs, rubs
d. Palpate peripheral arteries to detect diminished quality
e. Auscultate peripheral arteries for bruits

13. Examine thorax and lungs

a. Inspect thorax for symmetry of movement
b. Palpate for chest wall tenderness and tactile fremitus
c. Percuss chest to detect resonance
d. Auscultate lungs to detect abnormal sounds, i.e., wheezing, rales, rhonchi, or diminished breath sounds

14. Examine abdomen

a. Inspect abdomen for collateral circulation, scars
b. Auscultate abdomen for bowel sounds, vascular bruits
c. Palpate abdomen for tenderness, guarding, organ enlargement, or masses
d. Percuss abdomen for organ placement or ascites
e. Palpate for inguinal, femoral, ventral hernias

15. Examine male/female genitalia

a. Inspect breasts for deformity
b. Palpate breasts for masses/nodes
c. Inspect external genitalia
d. Accomplish specular examination of vagina and cervix
e. Perform bimanual pelvic examination
f. Palpate to determine height of fundus and position of fetus in pregnancy

16. Examine extremities

a. Palpate extremities for pulses, edema, varicosities, bone or joint tenderness
b. Inspect extremities for deformity, signs of fractures, swelling
c. Determine range of motion over joints, i.e., internal derangement
d. Inspect and palpate spine for deformity, tenderness
e. Evaluate muscles for strength, size, tone, tenderness

17. Examine nervous system

a. Test function of cranial nerves
b. Test coordination and cerebellar function
c. Test sensation
d. Test reflexes
e. Evaluate mental status

18. Examine lymph nodes

a. Palpate cervical, supraclavicular, axillary, and inguinal nodes

19. Demonstrate concern for patient's privacy, modesty, anxieties during the examination

a. Explain procedures
b. Drape patient appropriately
c. Check on patient's comfort
d. Warm instruments
e. Respond to patient's inquiries

20. Utilize data to support or modify tentative diagnostic impressions developed from history

C. Order and/or perform diagnostic tests

1. Perform the following screening tests:

a. Developmental screening of children such as Denver Developmental Screening test
b. Mental health screening of adults, such as Beck Depression Index, Cornell Medical Index
c. Visual screening with Schnellen chart
d. Visual screening with Titmus apparatus
e. Screening audiometry to test hearing
f. Electrocardiogram
g. Tuberculin test
h. Urinalysis
i. Guaiac of stool for occult blood
j. Routine specimen plating
k. Gram stain of urine and sputum
l. KOH and hanging drop preparation
m. Proctosigmoidoscopy
n. Perform intradermal testing
o. Screening Spirometry
p. Hematocrit
q. White blood count
r. Peripheral blood smear
s. Tonometry

2. Order:

a. SMA -- 6/12
b. VDRL
c. Triglycerides and cholesterol
d. Fasting -- 2 hour pc sugar
e. Oral glucose tolerance test
f. Blood for type and cross match
g. Coomb's test
h. Mono spot test
i. Sedimentation rate
j. Prothrombin time
k. Pregnancy test
l. Exercise tolerance test
m. Joint fluid aspiration
n. Complete blood count
o. Lumbar puncture
p. Thoracentesis
q. Culdocentesis
r. Paracentesis
s. Extremity X-ray
t. Skull X-ray
u. Chest X-ray -- PA and Lat

v. Abdomen X-ray -- AP and Lat
w. Other tests specific to age/race/sex categories

3. Obtain the following specimens for laboratory evaluation:

a. Blood
b. Urine
c. Stool
d. Vaginal secretions
e. Tissue
f. Wound
g. Sputum

D. Record and transmit findings

1. Summarize pertinent aspects of history

2. Summarize pertinent aspects of physical examination

3. Prepare patient summaries, progress notes

4. Write accident/incident reports

5. Prepare correspondence

6. Record immunizations on special records

7. Prepare records for clinic (organize history, physical examination, lab data)

II. Analyze Data Base to Formulate Management Plan

A. Differentiate between normal and abnormal (including variations of normal) information contained in the data base, including:

1. Adult history

2. Child history

3. Pregnant woman history

4. Adult physical examination

5. Newborn physical examination

6. Child physical examination

7. Pregnant woman physical examination

8. Screening examinations

9. Interpret results of diagnostic tests, such as routine X-rays of the chest and extremities

B. Develop diagnostic impressions based on data obtained

C. Order more definitive diagnostic tests

D. Establish preliminary diagnosis of common problems with physician guidance*

1. Abdominal pain

2. Abortion, spontaneous

3. Abuse of alcohol

4. Acute gastritis or duodenitis

5. Allergies

6. Amenorrhea, menorrhagia, metrorrhagia

7. Anal fissure and fistula

8. Arterial sclerosis, arterial scholoritic cardiovascular disease

9. Arthritis, osteoarthritis/rheumatoid arthritis

10. Asthma

11. Back pain

12. Benign or unspecified hypertension

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* Adapted from "Content of Family Practice," by David W. Marsland, M.D., Maurice Wood, M.B., and Fitzhugh Mayo, M.D. The Journal of Family Practice, Vol. 3, No. 1, 1976.

13. Boil and carbuncle
14. Bronchitis, acute and chronic
15. Burns, first degree
16. Bursitis
17. Cellulitis
18. Congestive heart failure
19. Conjunctivitis and ophthalmia
20. Constipation
21. Coryza, febrile cold, influenza-like illness
22. Cough
23. Debility or fatigue
24. Diabetes mellitus
25. Diarrhea and/or vomiting, viral gastroenteritis
26. Diseases of teeth and supporting structures
27. Drug abuse
28. Drug reactions
29. Duodenal ulcer
30. Emphysema without bronchitis
31. Epistaxis
32. Excessive smoking
33. Family relationship problems
34. Foreign body not entering through orifice
35. Glaucoma

36. Gonorrhea/syphilis

37. Gout

38. Headache, tension headache, migraine

39. Hematuria

40. Hemorrhoid

41. Iron deficiency, anemia

42. Lacerations, contusions, abrasions, insect bites

43. Laryngitis and tracheitis

44. Melena

45. Menopausal symptoms

46. Mental retardation

47. Mild mental health problems:

    a. Anxiety neurosis
    b. Depressive neurosis
    c. Obsessive-compulsive neurosis
    d. Physical disorders of presumably psychogenic origin
    e. Situational reactions such as marital, divorce
    f. Social isolation

48. Obesity

49. Otitis externa

50. Otitis media

51. Peripheral arterial disease

52. Pharyngitis, tonsillitis

53. Phlebitis and thrombophlebitis

54. Pleurisy

55. Pneumonia

56. Precordial pain/ischemic heart disease

57. Prostatic hypertrophy

58. Rhinitis/vasomotor or allergic

59. Sexual problems, e.g., impotency, frigidity, dyspareunia

60. Sinusitis

61. Skin problems:

    a. Allergic
    b. Dermatitis
    c. Dermatophytosis
    d. Disease of nail and nail bed
    e. Eczema
    f. Hair and hair follicle problems
    g. Rashes
    h. Sweat/sebaceous gland problems/acne
    i. Viral warts

62. Social problems:

    a. Economic
    b. Educational
    c. Employment
    d. Housing
    e. Legal
    f. Recreational

63. Sprains and strains

64. Tonsillar and adenoidal hypertrophy

65. Urethritis, non-venereal

66. Urinary tract infection

67. Varicose veins of lower extremities

68. Vascular lesions

69. Vertigo

70. Vulvitis, vaginitis, cervicitis

71. Wax in ear

72. Weight loss

III. Develop/Formulate Health Management Plan

A. Confer with patient

B. Confer with supervising physician as appropriate

C. Confer with patient's family as appropriate

D. Consult other professionals as appropriate

E. Use community resources as appropriate

IV. Implement and Monitor Health Management Plan

A. Apply established therapeutic practices to patient's problems

B. Implement management plan

1. Medical therapies/procedures

a. Administer medications

1. Oral
2. Topical
3. Sublingual
4. Rectal
5. Inhalation
6. Intravenous
7. Subcutaneous
8. Intradermal
9. Intramuscular
10. Intracardiac

b. Perform intubations/cannulations

1. Insert urinary catheter (straight or Foley)
2. Insert nasogastric tube
3. Insert intravenous catheters
4. Insert oral airway

c. Perform musculoskeletal therapies

1. Prepare, apply, and remove casts
2. Immobilize injured extremity
3. Tape joints for increased stabilization
4. Measure and adjust crutches
5. Instruct patient in proper use of crutches
6. Instruct patient about orthopedic exercises

d. Perform pulmonary therapies

1. Assist respiration using positive pressure bag (Ambu bag)
2. Set up oxygen equipment
3. Administer oxygen by venturi mask and nasal cannula
4. Set up and regulate vaporizer and nebulizer
5. Order appropriate pulmonary therapies

e. Perform eye, ear, nose, and throat therapies

1. Clean ears of impacted wax using curette and/or irrigation
2. Suction nose/mouth
3. Suction deep posterior pharynx
4. Suction trachea via tracheostomy
5. Irrigate eye
6. Apply eye patch
7. Control simple anterior nasal bleeding
8. Remove and clean inner cannula of tracheostomy

f. Perform cardiovascular therapies

1. Perform closed chest cardiac massage
2. Perform artificial respiratory ventilation
3. Apply rotating tourniquets
4. Set defibrillator intensity and discharge
5. Measure central venous pressure

g. Perform gastrointestinal therapies

1. Give enema
2. Remove fecal impaction

3. Perform gastric lavage
4. Perform stomal care
5. Irrigate gastrostomy

h. Perform genitourinary therapies

1. Give prostatic massage
2. Perform bladder irrigation
3. Give nephrostomy care
4. Perform supra-pubic bladder aspiration

i. Perform obstetrical/gynecological therapies

1. Insert I.U.D.
2. Cauterize cervix

j. Perform minor surgical procedures

1. Institute appropriate aseptic techniques
2. Perform wound care
3. Remove sutures
4. Remove/insert packings in wounds, incisions, cavities
5. Remove/insert and adjust wound drains
6. Administer digital block anesthesia
7. Administer topical, local anesthesia
8. Biopsy/excise superficial skin lesions, tumors
9. Perform circumcision on infants

k. Perform minor surgical therapies

1. Suture minor lacerations
2. Control bleeding/hemorrhage
3. Incise and drain subcutaneous abcesses
4. Remove subcutaneous foreign bodies
5. Apply dressings and wraps
6. Remove foreign bodies from nose, ear canal, external eye
7. Treat warts
8. Remove ingrown toenail
9. Apply burn dressing
10. Remove embedded ticks

l. Initiate basic management for emergency situations

1. Severe drug reaction, anaphylaxis
2. Shock (cardiogenic, hemorrhagic)

3. Lacerations
4. Sprains, strains, torn ligaments
5. Fractures
6. Internal hemorrhage
7. External hemorrhage
8. Respiratory impairment/arrest
9. Cardiac arrest
10. Acute myocardial infarction
11. Convulsions
12. Psychiatric crises
13. Burns (chemical, electrical, thermal)
14. Bites (animal, human, insect, fish)
15. Altered states of consciousness
16. Insulin shock/hypoglycemia
17. Heat exhaustion/stroke
18. Drug/chemical ingestion/poisoning
19. Traumatic amputation
20. Spinal cord injury
21. Eye injury
22. Head, chest, abdominal injury
23. Drowning (near)
24. Dehydration/volume depletion
25. Precipitous delivery
26. Neonatal apnea
27. Pack vagina
28. Carry out uncomplicated delivery

2. Provide patient education/counseling

a. Elicit information from the patient to determine understanding/acceptance of health problem

b. Decide on appropriate mode/procedures for presenting information

c. Discuss preventive health care measures with patient and family

1. Use of seat belts and child restraints in cars
2. Importance of exercise and diet
3. Implications of using tobacco and alcohol
4. Daily dental hygiene and yearly check-ups
5. Breast self-examination/Pap smear
6. Warning signs of cancer
7. Periodic physical examination
8. Accident prevention

9. Immunizations

d. Teach patient and family about:

1. Adequate nutrition
2. Poisoning prevention
3. Lead poisoning control
4. First aid
5. Prevention of infections
6. Congenital abnormalities and handicapping conditions
7. Administering injections
8. Use of vaporizer
9. Available community resources and agency services
10. Symptomatic therapy for fever (home care)
11. Symptomatic therapy for congestion (home care)
12. Symptomatic therapy for diarrhea (home care)
13. Symptomatic therapy for constipation (home care)
14. Symptomatic therapy for minor aches and pains (home care)
15. Symptomatic therapy for nausea and vomiting (home care)
16. Pregnancy, childbirth, and parenthood

    a. Early signs of labor
    b. Labor and delivery
    c. Abdominal pains during pregnancy
    d. Leg cramps during pregnancy
    e. Bleeding and discharge during pregnancy
    f. Breast enlargement postnatally
    g. Cradle cap
    h. Teething
    i. Pinworms
    j. Growth and development
    k. Teenage problems
    l. Day care center services
    m. Prepartum and postpartum exercises
    n. Newborn care
    o. Feeding of newborns
    p. Bathing of newborns
    q. Loving and holding
    r. Umbilical cord care
    s. Diapering
    t. Fetal growth

e. Provide resources for patient education

1. Recommend/provide supplementary health education

pamphlets/books
2. Review films and pamphlets for selected groups
3. Distribute health literature

f. Provide sex education

g. Explain the meaning of the patient's problem(s) and purposes of treatment for:*

1. Abdominal pain
2. Abortion, spontaneous
3. Abuse of alcohol
4. Acute gastritis or duodenitis
5. Allergies
6. Amenorrhea, menorrhagia, metrorrhagia
7. Anal fissure and fistula
8. Arterial sclerosis, arterial scholoritic cardiovascular disease
9. Arthritis, osteoarthritis/rheumatoid arthritis
10. Asthma
11. Back pain
12. Benign or unspecified hypertension
13. Boil and carbuncle
14. Bronchitis, acute and chronic
15. Burns, first degree
16. Bursitis
17. Cellulitis
18. Congestive heart failure
19. Conjunctivitis and ophthalmia
20. Constipation
21. Coryza, febrile cold, influenza-like illness
22. Cough
23. Debility or fatigue
24. Diabetes mellitus
25. Diarrhea and/or vomiting, viral gastroenteritis
26. Diseases of teeth and supporting structures
27. Drug abuse
28. Drug reactions
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32. Excessive smoking
33. Family relationship problems
34. Foreign body not entering through orifice
35. Glaucoma
36. Gonorrhea/syphilis
37. Gout
38. Headache, tension headache, migraine
39. Hematuria
40. Hemorrhoid
41. Iron deficiency, anemia
42. Lacerations, contusions, abrasions, insect bites
43. Laryngitis and tracheitis
44. Melena
45. Menopausal symptoms
46. Mental retardation
47. Mild mental health problems:

    a. Anxiety neurosis
    b. Depressive neurosis
    c. Obsessive-compulsive neurosis
    d. Physical disorders of presumably psychogenic origin
    e. Situational reactions such as marital, divorce
    f. Social isolation

48. Obesity
49. Otitis externa
50. Otitis media
51. Peripheral arterial disease
52. Pharyngitis, tonsillitis
53. Phlebitis and thrombophlebitis
54. Pleurisy
55. Pneumonia
56. Precordial pain/ischemic heart disease
57. Prostatic hypertrophy
58. Rhinitis/vasomotor or allergic
59. Sexual problems, e.g., impotency, frigidity, dypareunia
60. Sinusitis
61. Skin problems:

    a. Allergic
    b. Dermatitis
    c. Dermatophytosis
    d. Disease of nail and nail bed
    e. Eczema
    f. Hair and hair follicle problems

g. Rashes
h. Sweat/sebaceous gland problems/acne
i. Viral warts

62. Social problems:

a. Economic
b. Educational
c. Employment
d. Housing
e. Legal
f. Recreational

63. Sprains and strains
64. Tonsillar and adenoidal hypertrophy
65. Urethritis, non-venereal
66. Urinary tract infection
67. Varicose veins of lower extremities
68. Vascular lesions
69. Vertigo
70. Vulvitis, vaginitis, cervitis
71. Wax in ear
71. Weight loss

3. Facilitate/counsel patient concerning non-referral mental health problems

a. Assist patient in handling/exposing feelings
b. Observe patient for behavioral/mood changes
c. Encourage patient to ventilate/express feelings
d. Listen to patient/family express feelings on illness/death
e. Listen to patient/family discuss personal problems
f. Identify factors influencing patient's psychological state
g. Relate patient's psychological needs to his physical ability
h. Support family in dealing with patient's condition/progress
i. Counsel patient concerning:

1. Anxiety reactions
2. Maladaptive disorders
3. Depression, non-psychotic
4. Adjustments to aging
5. Development problems of adolescence
6. Behavioral problems of children and adults
7. Chronic illness/handicapping conditions
8. Terminal illness

9. Psychosomatic illness

4. Appropriate use of community resources

a. Family planning agencies
b. Mental health agencies
c. Social service agencies
d. Legal services
e. Housing agencies
f. Consumer protection agencies
g. Recreational facilities

C. Perform general preventive/screening/prenatal care

V. Demonstrate Evidence of Attributes Essential to a Professional

A. Know and accept that the role of the physician assistant is limited by:

1. Supervising physician

2. Legal limitations

3. Local circumstances

4. Individual competencies

B. Establish effective interpersonal relationships with patients, professionals, and others

1. Accept and respect feelings and attitudes of others

2. Respond to personal and cultural factors affecting patient compliance

3. Demonstrate empathy and caring about patient

4. Take into consideration the cost implications of one's decisions on behalf of the patient

5. Reassure patient during all interactions

6. Question patients in terms that are appropriate to their level of understanding

7. Modify interviewing techniques where appropriate

8. Seek out a qualified physician employer

C. Maintain attributes and express attitudes essential to the role of a professional

1. Maintain confidentiality of patient information
2. Admit to errors made in the evaluation of patients
3. Accept criticism of errors of judgement
4. Seek answers
5. Correct knowledge deficiencies through continued education
6. Maintain and expand theoretical knowledge base
7. Develop tolerance in coping with stress of being involved with emerging profession
8. Develop confidence in professional identity
9. Understand and accept limits of therapeutic success
10. Avoid allowing personal beliefs/prejudices to interfere with functions
11. Accept patient's limitations in perceiving health status
12. Accept patient's ability (inability) to comply with therapeutic programs
13. Accept existing uncertainties in the management of personal health
14. Accept limits of own capabilities and negative feelings of others in case of failure
15. Acknowledge limitations of community resources
16. Show patience in dealing with change process
17. Be persistent in effecting constructive change

D. Resist compromises in the practice of medicine when conflicting with personal ethics

VI. Refer Patients as Necessary

A. Refer patients with problems beyond one's professional competencies to appropriate sources of care such as:

1. Supervising physician

2. Other health professionals

3. Community resources agencies

B. Maintain relationship with patients referred

1. Explain to patients why referral is necessary

2. Continue to monitor referred patient's progress

3. Provide information pertinent to consultation/referral

4. Update patient's record according to referral outcome

VII. Prepare and Carry Out Strategies to Promote Acceptance of the Role Within the Professional/Patient Community

A. Explain role by actions and words to others

B. Display sensitivity to the partial overlapping and possible sharing of responsibilities with other health professionals

C. Use (formal and informal conflict resolution) techniques including adjusting activities, fostering improved working relationships, helping behavior

D. Transmit reference materials to relevant professionals concerning physician assistant's functions and utilization

E. Assess within the work group the behavior of individuals and group actions to facilitate problem solving or prevent problems from arising

F. Know and implement strategies useful in gaining acceptance of the role within the community

VIII. Maintain Competency Through Continuing Medical Education

A. Engage in periodic review of professional skills (self-assessment)

B. Devise program of CME activities based upon perceived needs

C. Acquire knowledge and skills essential to incorporating into practice proven new evaluation/treatment modalities