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Physicians Assistants 5/25

facsimile
TRANSMITTAL

to: Liz Boyer
fax #: 456-2239
re: physician assistants
date: May 24, 1994
pages: page(s) total, including this cover sheet

Liz-

Please give me a call after you have read the talking points.

Hope this is helpful!

--Margie

From the desk of...

Marjorie Ross
Policy Advisor
Office of the Assistant Secretary for Health

tel:
fax:

Physician Assistants and the Health Security Act

Increased Role under Health Care Reform

- Physician Assistants will be given an increased role under reform: the Health Security Act (HSA) defines health professional services to include those services which could be performed by a physician and which are provided by another person who is legally authorized to provide those services in a particular state. The HSA does not identify specific providers of services. Plans will be free to use any mix of providers to meet the needs of their enrollees.

- Increased Demand in Professional Role:

  Universal coverage will increase the demand for qualified health professionals. Health plans will be rewarded by making best use of quality providers. In order to compete on cost and quality, health plans will be given new incentives to include PAs in their provider networks. It is expected that physician assistants, who provide cost effective care, will be in demand for the provision of health care services in any of the following settings:

  -- Hospitals
  -- Primary Care
  -- Public Health
  -- Medically Underserved Areas

- Research the effectiveness of PA Role:

  $2.85 million authorized under Title III for health services research. One priority is to assess the appropriateness and effectiveness of alternative clinical strategies for primary care and other specialties. It is expected that the role of the PA will be expanded as a result of this research.

Increased Funding for PA Training

- HSA authorizes $200 million a year over the next 5 years from USDHHS. Grants can be used for training of primary care physicians assistants, training of underrepresented minorities and disadvantaged persons including recruitment, retention and financial assistance for persons entering health professions.

- HSA authorizes $200 million a year for programs administered by the Department of Labor including a new National Institute for Health Care Workforce Development (joint venture DOL and DHHS).

- The HSA authorizes an additional $100 million a year (over current appropriations) to increase the National Health Service Corps five fold, to which Physician Assistants can apply for loan repayment.

Mental Health/Substance Abuse Benefits

- The HSA provides coverage for mental illness and substance abuse treatment which will be phased in so that by 2001 all differences in insurance coverage between physical health and mental health/substance abuse services will be eliminated.

- The new benefit will encourage the use of proven, cost-effective innovative alternatives to inpatient treatment such as partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home-based services, and behavioral aide services. Physician assistants can play an important role in the expansion of such innovative services.

Services for the Underserved

- Physician assistants are eligible to receive a $500 a month credit for providing primary care services to underserved populations

- The public health initiatives provide programs to assure access to health services for urban and rural medically-underserved populations by expanding capacity and by supporting the provision of outreach and enabling services.

- A new program would provide grants and contacts for enabling services including transportation, community and patient outreach, patient education, translation and other services that will facilitate access to the services in the comprehensive benefits package. Physician assistants would be key coordinators and providers of such enabling services.

- $2.7 billion authorized for capacity expansion into underserved areas. Can be used for development of community based health plans and developing networks of providers.

Home and Community-Based Services Program

- The HSA includes a new federal/state program of home and community-based services targeted to people of all ages with significant disabilities. There is no income or means test for eligibility for this program.

- Under this program, states must provide initial screening of patients for eligibility. Eligible patients will receive comprehensive assessments and care plans. At a minimum,

states must provide personal assistance services including assistance, supervision and cuing to perform activities of daily living (ADLs). Physician assistants can serve in this new program in the determination of patient eligibility, as providers of assessments and in the development of care plans.

- Optional services under this program include case management, respite care, adult day services, habilitation services, and home health services. Several states have expressed an interest in developing case management services under this new program; the role of physicians assistants in such systems is critical.

School-Based Programs

- The HSA's public health initiatives include funding for school-related health services and comprehensive school health education.

- School-related health services will be funded through development and operational grants to assess community needs, link school-health activities to health plans and alliances, conduct outreach activities, provide enabling services, and to provide health services that are not covered under HSA's guaranteed benefits package. Physician Assistants may serve in a number of capacities in such programs, particularly in efforts to conduct outreach activities and coordinate enabling services.

- Comprehensive school health education programs will include planning grants for assessment, capacity building and curriculum development, and implementation grants to both state and local education agencies.

American Academy of Physician Assistants

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Alexandria, Virginia 22314

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May 3, 1994

Philip Lee, M.D.
Assistant Secretary for Health
Department of Health and Human Services
Huber H. Humphrey Building, Room 716-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Phil:

The Administration's "Health Security Act," (HR 3600, S 1757) proposes increased utilization of physician assistants (PAs) and advanced practice nurses in the delivery of primary and preventive care. The bill authorizes an additional $400 million for federal categorical grant programs that support primary care physicians, PAs and advanced practice nurses.

This legislation is evenhanded in its approach to PAs and advanced practice nurses except for one provision -- the earmarking of $200 million for Graduate Nurse Education ($100 million each from the funds for Medicare GME and for academic health centers). **This inequity should be remedied by the inclusion of a similar provision for support of PA educational programs from a dedicated funding source, such as GME.**

Justification

In the Administration's reform bill, funds will be made available for the graduate training of physicians in clinical settings outside of traditional hospital-based programs. Two hundred million dollars have also been identified for the graduate training of advanced practice nurses, virtually all of which occurs in outpatient and community practice settings.

At present, clinical training sites for PAs and NPs receive no reimbursement. In addition, there has been minimal competition for these training sites from physicians. If the provisions of health reform discussed above are adopted and implemented as envisioned, however, physicians will be competing with PAs and NPs for these training opportunities. Without comparable funding to support PA clinical training, PA students will be at a tremendous and untenable competitive disadvantage. **The result of funding physician and NP graduate education without funding PA clinical education will be the severe restriction of training opportunities for PAs.** The future supply of PAs could be threatened substantially.

Proposal

At the present time, roughly equal numbers of PAs and NPs are being trained each year. **We would propose that an additional $200 million from a dedicated funding source comparable to that established for nursing be specified for the graduate training of PAs.** This funding would be used to: (1) provide tuition and stipend support for the services offered by PAs as part of their training; (2) reimburse clinical sites for the supervision and education provided to PAs; and (3) pay PA programs for the administrative costs of organizing and overseeing the clinical training portion of PA education.

TC84454
TRACER

The issue of support for the clinical training of PAs is one of the most important issues for the PA profession. Please feel free to contact me at any time to obtain further information and background about this issue.

Thank you for your consideration of this issue. I look forward to working with you on the solution to this problem.

Sincerely,

Stephen C. Crane, PhD, MPH
Executive Vice President

cc: Brian Biles, MD
Ann Elderkin, PA, President
Deborah Gerbert, PA, President-elect
Nicole Gara, Director of Government and Professional Affairs
Bill Finerfrock, Capitol Associates

Special Communication

Physician Assistants and Health System Reform

Clinical Capabilities, Practice Activities, and Potential Roles

P. Eugene Jones, PhD, PA-C, James F. Cawley, MPH, PA-C

NATIONAL efforts to reform the health care system will likely result in changes in the roles and responsibilities, practice combinations, and distribution of health professionals, including midlevel providers such as physician assistants (PAs), nurse practitioners (NPs), and certified nurse-midwives. Although recent studies have addressed differing scenarios of the projected roles of midlevel providers,[1-5] implementation of initiatives that involve PAs may be influenced by an overall shortage of PAs, existing barriers to PA practice, and the need for commitment to physician-dependent practice relationships in a team-oriented health care delivery system. This article reviews the history, academic preparation, clinical capabilities, distribution, and practice activities of PAs and discusses the potential roles of PAs in the changing health system environment.

The origin of the PA can be traced to the new health practitioner movement of the 1960s, during which the PA concept emerged from a combination of events. As experienced hospital corpsmen and combat medics returned from service in Vietnam, there were no civilian job equivalents or suitable health career pathways in the United States. Simultaneously, a new health care provider model proposed in 1961[6] resulted in the development of the first PA program at Duke University School of Medicine. According to this concept, PAs "would be trained to assist the doctor . . . in such a way as to facilitate better utilization of available physicians and nurses."[7] These circumstances eventually resulted in the matriculation of substantial numbers of military veterans into newly developing PA programs. Subsequently, more PA programs were developed to train providers who would (1) augment the capabilities of primary care physicians by increasing access to basic medical care services, (2) fill service gaps resulting from geographic and specialty maldistribution of physicians, and (3) help control health care costs.[8,9]

From the Physician Assistant Program, Department of Health Care Sciences, University of Texas Southwestern Medical Center at Dallas (Dr Jones), and the Physician Assistant Program, Department of Health Care Sciences, The George Washington University, Washington, DC (Mr Cawley).

Reprint requests to University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235-9090 (Dr Jones).

PA EDUCATION

By 1993, there were 58 accredited PA programs in 29 states and the District of Columbia and 2,408 program graduates.[10,11] With the exception of a few hospital-, military-, and community college–based programs, the majority of PA programs are affiliated with academic health centers (AHCs), medical schools, or 4-year colleges and universities, 26% of which are classified as category I research universities by the Carnegie Foundation for the Advancement of Teaching.[12] Thirty-five PA programs (60%) offer a baccalaureate degree or degree option, 12 (21%) offer master's degrees, and the remainder grant an associate degree or a certificate of completion.

Essentials for PA Education

The "Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician" were initially adopted in 1971 by the American Medical Association in collaboration with the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Society of Internal Medicine.[13] Following the organization of the Committee on Allied Health Education and Accreditation in 1977, the Essentials were revised in 1978, 1985, and 1990. The Essentials establish minimum standards of quality to which accredited programs are held accountable. After the Essentials initially were adopted, federal funding acts supported the expansion of PA educational programs' emphasis on a primary care orientation for preparing generalist PAs.[14]

According to the current Essentials of the Committee on Allied Health Education and Accreditation, PAs are "academically and clinically prepared to provide health care services with the direction and responsible supervision of a doctor of medicine or osteopathy. The functions of the physician assistant include performing diagnostic, therapeutic, preventive and health maintenance services in any setting in which the physician renders care, in order to allow more effective and focused application of the physician's particular knowledge and skills."[15(p6)]

Clinical services performed by PAs are described by the Essentials in the following six categories[15(pp6-7)]: (1) *evaluation*—initially approaching a patient of any age group in any setting to elicit a detailed and accurate history, perform an appropriate physical examination, delineate problems, and record and present the data; (2) *monitoring*—assisting the physician in conducting rounds in acute and long-term inpatient care settings, developing and implementing patient management plans, recording progress notes, and assisting in the provision of continuity of care in office-based and other ambulatory care settings; (3) *diagnostics*—performing and/or interpreting, at least to the point of recognizing deviations from the norm, common laboratory, radiological, cardiographic, and other routine diagnostic procedures used to identify pathophysiological processes; (4) *therapeutics*—performing routine procedures such as injections, immunizations, suturing and wound care, management of simple conditions produced by infection or trauma, and assistance in the management of more complex illness and injury, which may include assisting surgeons in the conduct of operations and taking initiative in performing evaluation and therapeutic procedures in response to life-threatening situations; (5) *counseling*—instruction

and counseling of patients regarding compliance with prescribed therapeutic regimens, normal growth and development, family planning, emotional problems of daily living, and health maintenance; and (6) *referral*—facilitating the referral of patients to community health and social service agencies when appropriate.

Curriculum Content

Prior to matriculation, the typical PA program requires the student to have completed the equivalent of 2 years of undergraduate-level biological, social, and behavioral science prerequisites. The first 9 to 12 months of PA education are devoted to preclinical didactic studies and include courses in anatomy, physiology, microbiology, pharmacology, psychology, clinical medicine, physical diagnosis, preventive medicine, and clinical laboratory procedures.[16] Courses in the basic medical sciences account for 77% of the didactic component of PA education, with the remainder devoted to behavioral and social sciences. Educational programs for PAs average more than 1004 contact hours of didactic instruction.[17] These courses are typically followed by 9 to 15 months of physician-supervised clinical education in both inpatient and outpatient settings in urban, inner-city, and rural communities.

In some AHCs, didactic PA education and medical student education is conducted with shared classes and resources, and PA students typically are educated in a clinical setting by residents, attending physicians, and graduate PAs. Most programs include supervised clinical educational experiences for PA students in rural or medically underserved areas. In addition, several hospital- and university-based postgraduate courses of instruction exist in medical and surgical specialties such as neonatology, pediatrics, emergency medicine, occupational medicine, and surgery.

Primary Care Deployment Models

A number of PA programs have developed specialized curricula designed to promote primary care practice in underserved communities, including content on substance abuse education for health professionals, geriatrics, mental health, health care for the homeless, women's health initiatives, environmental/occupational medicine, medical Spanish, and a general orientation toward prevention in the delivery of health care.[14] Many programs have successfully placed graduates in chronically underserved areas via decentralized educational projects.[18,19] For example, participants in the Stanford University Primary Care Associate Program were twice as likely to be employed in rural communities (<10 000 population) as nonparticipants (33% vs 16%).[20] A 1992 survey of participants in the University of Nebraska PA Program's Rural Health Opportunities Project revealed a similar graduate employment rate (33.4%) in communities with fewer than 10 000 population.[21] More recently, a satellite educational project developed by the University of Washington–MEDEX Northwest Physician Assistant Program provides on-site didactic and clinical education for rural and Native Alaskan matriculants in Sitka, Alaska, and additional MEDEX Northwest projects link the University of Nevada and Boise State University with area health education centers for rural PA deployment.

Several PA programs have developed master's degree majors for PAs who will serve underserved populations and areas of special need. Graduate PA programs in rural health are offered at Alderson-Broaddus College in Philippi, WVa, and the University of Nebraska–Omaha. Public health education is offered in combined PA/MPH programs at The George Washington University, Washington, DC, and the University of Oklahoma in Oklahoma City, and a combined PA/MS degree in preventive medicine is offered at the University of Iowa in Iowa City.

AHC-Affiliated PA Programs

Of the 58 accredited primary care PA programs, 27 (47%) are sponsored by AHCs. Twice as many AHC-based PA programs receive federal grant support as non–AHC-based programs, and at a 12% greater dollar amount than non–AHC-based PA programs. Because federal PA training grants are tied to demonstrated success in primary care education and graduate placement in health professional shortage areas, it follows that AHC-sponsored PA students spend more time in primary care–based clinical education and are employed in primary care settings at a greater rate than non–AHC-sponsored students.[22] Consequently, AHC-based PA programs may be better positioned than non–AHC-based programs to contribute to the goals of the Health of the Public Program[23] by providing interdisciplinary didactic and clinical education in population-based competencies, by continuing emphasis on health promotion and disease prevention activities,[24] and through PA faculty service and student rotations that augment community access to health care services.

Funding Sources

In 1993, 38 PA programs received a total of $6.65 million in federal training support under Title VII authorization through the Health Resources and Services Administration Grants Program for Physician Assistants of the Public Health Service, administered by the Division of Medicine. In the same year, the mean PA program budget was $457 000 and the average Title VII grant award was $143 000, which accounted for 28% of program operating costs.[22] Fiscal year 1995 authorization is $9 million.

Title VII funding preferences and priorities for PA program education grants have traditionally emphasized primary care education and deployment, affiliation with graduate programs in family medicine, and strategies for increased enrollment and retention of underrepresented minorities. Funding preferences and priorities for the fiscal year 1994 application cycle address medically underserved community practice, generalist specialty practice, and increased enrollment of minorities or low-income applicants.

From the inception of PA educational programs, internal support from sponsoring institutions has increased steadily while external (primarily federal) support has remained at about one third of total program revenues. This trend reflects increasing self-sufficiency on the part of PA programs, because the level of federal support during the past 7 years has remained relatively constant.

The overall cost of PA education remains relatively low. The average total cost for educating a PA student is approximately $8029 per year at AHC-sponsored programs and $7546 per year at non–AHC-sponsored programs.[22]

Response to Federal Initiatives

Educational programs for PAs have responded to federal grant initiatives by specifically targeting curriculum content toward primary care for medically needy populations. This includes special focus on topics such as the acquired immunodeficiency syndrome, substance abuse, adolescent pregnancy, childhood immunizations, risks of cancer and heart disease, and reduction of infant mortality. More than half of all PA programs have developed specific educational content to address the health and medical problems of inner-city populations. Most PA programs have developed strong linkages with area health education centers, community education centers, rural health clinics, community/migrant health centers, and other primary health care agencies and settings. Fellowships for PAs in migrant health centers are jointly sponsored by the Health Resources and Service Administration, National Rural Health Association, American Academy of Physician Assistants, and Association of Physician Assistant

Table 1.—Physician Assistant Specialty Distribution, by Percentage, 1974 Through 1993*

Specialty	1974 N=939	1978 N=3416	1981 N=4312	1984 N=8552	1987 N=10 692	1993 N=14 746
Family practice	43.8	52.0	49.1	42.5	38.7	34.5
General internal medicine	20.0	12.0	8.9	9.2	9.5	9.5
General pediatrics	6.2	3.3	3.4	4.1	4.0	2.3
General surgery	12.1	5.5	4.6	5.1	8.8	6.4
Surgical specialties	6.8	8.2	7.7	12.5	13.8	20.6
Medical specialties	3.9	6.9	2.7	4.6	7.1	5.0
Emergency medicine	1.3	4.9	4.5	6.4	6.5	8.2
Occupational medicine	1.8	2.7	3.1	4.1	4.1	3.1
Other†	4.3	7.1	16.0	11.3	7.5	9.4

*Sources of data are references 10 and 28.
†Other includes pediatric specialties, physical and rehabilitation medicine, psychiatry, public health, and radiology (all <1%); 3.3% were not identified.

Programs to promote PA practice in migrant health settings.

Faculty

Educational programs for PAs experience difficulty in identifying, recruiting, educating, and retaining sufficient numbers of qualified faculty members. The combination of an enlarging applicant pool, pressure to increase the number of PAs trained per program, and an increasing number of clinical employment opportunities has resulted in an "academic hourglass" effect, further complicated by an already insufficient supply of experienced PA educators. Because of the disparity between academic and clinical income potential, faculty positions designed as joint teaching–practicing clinician positions are commonplace means of income supplementation. Sixty-nine percent of PA faculty are concurrently engaged in part-time clinical practice, averaging 10 hours per week, earning an average wage of $26.29 per hour.[25]

As with most professional schools, no formal pathway exists for PA-specific educator training. Clinically experienced PAs are typically self-referred or recruited into PA education, usually with little or no formal preparation in the foundations of educational theory and practice.[25] Of the PA program personnel identified as faculty in 1993, 13.6% held doctorate degrees, 35.2% held master's degrees, and 49.2% held bachelor's degrees. The remaining 2% held associate degrees (1%) or were not reported.[22]

Applicants and Students

As with other health professions, interest in PA education continues to increase. In 1988, PA programs averaged 86.1 applicants for 25.9 seats. By 1992, the number of applications increased to an average of 203 per PA program (an increase of 136%), and the number of enrolled students increased to 35 per program.[22] Preliminary reports of the 1994 applicant pool indicate that many programs have nearly twice the number of applicants compared with 1993.

The typical student entering PA training is a 26-year-old white woman with a 3.1 grade point average and more than 4 years of previous health care experience. Since 1984, women have constituted more than 60% of enrolled PA students, and since 1987, ethnic minorities have represented about 20% of matriculants. Most students enter PA education with either a baccalaureate degree or substantial course work in the premedical sciences. An increasing number of matriculants (7.2% in 1993) hold master's or doctoral degrees.[26]

CLINICAL SERVICES AND SETTINGS

At present, approximately 23 350 PAs are employed in clinical practice in 49 states and the District of Columbia. Trends in practice patterns of recent PA program graduates reveal increased numbers in inpatient and institutionally based settings and, until recently, fewer entering primary care practice. In 1993, 44% of PAs were employed in primary care settings, defined as family or general practice, general internal medicine, or general pediatrics (Table 1). The largest share, 34.5%, worked in family or general practice.[10] The 28% of PAs employed by hospitals included more than 6% in outpatient clinic practice (Table 2).

The distribution of PA practice settings is geographically disproportionate. Fewer recent graduates of PA programs in eastern states entered primary care practice settings (54.4%) compared with graduates in central (73.8%) and western states (70%). Seventeen percent of PAs practice in communities with a population of fewer than 10 000, and 34% practice in communities with a population of fewer than 50 000. More than 86% of all graduate PAs remain in full-time clinical practice.[10]

Changing Profiles

The demographic profile of PAs has changed markedly since the profession's inception. Although it remains a relatively young profession (the mean age of PAs is 40 years), the proportion of women PAs is now more than 42%, increasing from less than 10% in the 1970s. Almost 10% of PAs are ethnic minorities, and more than 32% are military veterans.[10]

Nearly 35% of all PAs are employed in private physicians' practices (either solo or group) and 28.5% practice in hospitals, with other PAs distributed in health care settings such as managed care organizations (7.3%), the military (4.6%), rural clinics (4.7%), Department of Veterans Affairs facilities (4.2%), and correctional facilities (2.5%). The remainder practice in nursing homes, inner-city clinics, and other clinical settings. Notable employment trends reveal fewer PAs in family medicine and more PAs in medical and surgical subspecialties (Table 1). The proportion of PAs employed in hospital settings reflects a relatively stable distribution over the past decade (Table 2).[27]

While PA practice settings continue to diversify, the largest percentage remain employed in primary care. A number of the same socioeconomic factors that discourage physicians from practicing primary care may influence PA employment decisions as well.[9] Despite the fact that most PAs are in primary care practice, it is clear that specialty and institutional employers are competing for PA services, and the patterns of diversification and specialization of PA employment further complicate an imbalanced educational supply and occupational demand mismatch.[28]

Income

As demand for PA services has grown, salaries in both primary care and specialty settings have increased accordingly. In 1993, the mean annual salary for PAs in all practice settings and specialties was $53 500, excluding fringe benefits and part-time income. Those employed in surgical specialties earned an average of $60 800 per year.[29] In a 1991 study of 6228 PAs, with the exception of those in practice less than 1 year, salaries among men were approximately $5000 greater than among women, even after controlling for clinical specialty, number of years in practice, number of patient visits per week, and number of hours worked per week.[30]

PA Productivity and Cost-effectiveness

The potential roles to be assumed by PAs in health system reform will likely correlate with their productivity and cost-effectiveness. Outcomes will differ from practice to practice, depending on variables such as the specialty, setting, and barriers to employment. The productivity and cost-effectiveness of PAs have been described and measured by the time spent per visit, average num-

Table 2.—Trends in Physician Assistant Practice Settings, by Percentage, 1981 Through 1993*

Practice Setting	1981 N=4312	1984 N=6002	1987 N=3309	1993 N=14 746
Private office†	35.8	34.5	33.2	34.6
Hospital	28.5	31.9	30.0	26.5
Ambulatory clinic‡	24.9	17.7	17.0	20.4
Health maintenance organization	NA§	NA	6.9	7.3
Military	9.4	7.3	7.6	4.8
Other‖	0.4	9.2	6.7	4.6

*Sources of data are references 10 and 29. Data for 1987 are from reference 29 only.
†Either solo or group practice.
‡Includes community-based public, privately sponsored, inner city, substance abuse, student health, correctional medicine, and rural health clinics.
§NA indicates not available.
‖Other includes Veterans Affairs (4.2%) and nursing homes (0.4%).

ber of visits per unit of time, number of office visits or procedures, charges generated, overhead reduction, and increased physician activity.[4,31-34] In 1993, outpatient-based PAs saw an average of 22.1 patients per day, compared with an average of 15.7 patients per day for inpatient-based PAs.[10] Although many variables are influenced by the actual practice setting, the evidence suggests that physicians can increase their practices' output by employing PAs, and PAs "are capable of carrying substantial proportions of the workloads of primary-care physicians."[34(p83)]

Quality of Care

Indicators of the quality of care provided by PAs have been measured by comparing processes and outcomes between physician- and PA-provided care with regard to functions performed by both. Within their areas of competence, PAs have been shown to provide care indistinguishable in quality from care provided by physicians.[4,35] Indirect indicators of quality, such as physician acceptance and patient satisfaction, have also been favorable.[36,37] However, existing quality-of-care studies of midlevel providers have recently been criticized for being dated and methodologically flawed.[38] The need for current data derived by rigorous health services research methods is clearly indicated.

Responsibility and Accountability

State legislation governing PA scope of practice exempts PAs from the unlicensed practice of medicine with the stipulation that they function under the supervision of a licensed physician. Legally, the physician-PA relationship is one of *respondeat superior*, wherein the physician is liable for exercising care in the selection and supervision of the PA, has the right of control of the assistant, and is "liable for the negligent acts of employees performed within the scope of the employment relationship."[39(p108)] Although the supervising physician retains "vicarious liability," PA practice accountability has progressed from a delegatory model achieved by amending medical practice acts to a regulatory/authority model, wherein state licensing boards are authorized to govern PA practice. These amendments and exemptions establish PAs as the agents of their supervising physicians, and PAs maintain direct liability for the services they render to patients. Supervising physicians, who define the standard to which PA services are held, are vicariously liable for services performed by their PAs under the doctrine of *respondeat superior*.

COMPARING PAs AND NURSE PRACTITIONERS

A recent study estimated there are 27 226 NPs, distinguished from other registered nurses by state boards of nursing data. Exact numbers are unknown because of overlapping NP titles, specialty practice roles, and differing state requirements for NP education and accreditation.[40] The majority of NP practice settings were reported in family and adult medicine, pediatrics, and women's health.

A 1993 study of 51 midlevel provider educational programs (22 NP, 20 PA, two combined PA/NP, and seven certified nurse-midwife programs) compared legal, professional, and political differences between PAs and NPs.[19] Although varying degrees of differences and similarities were reported between PA and NP educational programs, the main distinction in their orientation to health care is that NP programs are typically set within schools of nursing, with education provided in the nursing model. In contrast, PA programs are typically affiliated with medical schools, with education provided primarily by physicians. However, these differences are less distinct in some regards; physicians contribute to NP education, and NP and PA educators often "cross-teach" between and among programs. In California, two programs jointly train PAs and NPs within the same department, and approximately one third of California PAs are also nurses.[41]

Although PA and NP clinical roles within managed care organizations and ambulatory settings are often regarded as interchangeable, reports comparing PA and NP productivity have differed in their findings. One study reported that both groups saw similar numbers of ambulatory adult patients in a large managed care setting,[42] whereas another reported that PAs had more direct patient encounters and generated twice the gross dollar income per day when compared with NPs.[43] These differences were not fully accounted for but were partially attributed to the tendency for NPs to spend more time providing counseling services. Debate continues on the practice productivity advantages and disadvantages between PAs and NPs, but researchers appear to agree that the potential for increased productivity for both groups is greater in larger practices and managed care settings. Nevertheless, both PAs and NPs directly reflect physician levels of task delegation in their clinical productivity.[4]

The practice of PAs is regulated under states' Medical Practice Act provisions and is based on physician supervision and task delegation, whereas NPs practice under nursing licensure provisions of Nurse Practice Acts. Research evidence clearly shows that the tasks described and roles performed by PAs and NPs are more similar than different in many ambulatory practice settings, but two major issues serve to differentiate the professions: (1) their general orientation to health care and (2) the desire for independent (NPs) vs dependent (PAs) practice relationships with physicians.[44] This divergence may have important implications for both professions if health reform measures include greater roles for PAs and NPs in private practices, managed care systems, and institutional settings.

POTENTIAL ROLES OF PAs

Under federal aegis, increasing attention is now focused on a generalist-provider–oriented system of health care. However, the projected roles of PAs in such a system are still undetermined. According to the US Public Health Service, PAs "have become firmly established as a provider group well suited to address problems of maldistribution of physicians and enhancing cost-effectiveness of care," and increasing demand for PA services was attributed to the revitalization of the National Health Service Corps, liberalization of authority to prescribe, and the increased use of PAs in hospital-based settings as a means of cost-control.[45(p7)] What remains to be seen is the level of demand and the clinical practice settings in which PA services will be required.

The federal government reinforces the

primary care focus of PA program curricula by awarding Title VII training grants for programs demonstrating a record of successfully meeting primary care–oriented funding preferences and priorities. However, the possible redistribution of medical and surgical subspecialty residency educational positions recently recommended to Congress by the Physician Payment Review Commission (PPRC) and the Council on Graduate Medical Education may result in increased use of PAs and other midlevel providers in inpatient specialty settings. This may occur as a result of a PPRC-projected loss of 11 000 residency slots.[48] Among the PPRC recommendations was a call for increased funding for specialty-trained PAs and other midlevel providers to maintain levels of inpatient care previously provided by residents. Another report reinforced this proposal, suggesting a need to determine "the extent to which nurse practitioners and physician assistants can substitute for and enhance both generalists and specialists. . . ."[2(p1078)]

The PA profession realizes increasing opportunities in medical and surgical specialty practice, and the 77% of PA programs that are federally funded are obligated to maintain generalist-based curricula. Although many newly graduated entry-level PAs are initially employed in specialty settings, the more plausible solution to the potential demand for more specialty-trained PAs may be to increase the number of postgraduate and master's level specialty programs. The projected number of PAs who will graduate in 1994 is 2100. If Title VII educational grants increase as projected, approximately 3300 PAs would graduate in 1996, followed by 3800 graduates in 1997. The annual PA graduation rate would increase to approximately 4000 by the year 2000, resulting in a total of approximately 41 000 PAs in practice. This number includes the assumption of a 1% to 3% attrition rate and the remaining years of expected practice, given the mean PA age of 40 years.[47] However, the distribution of PA practice settings will likely be influenced by a combination of market forces and reform initiatives.

Hospital-Based PAs

As the proportion of PAs working in primary care practices declined during the 1980s, the proportion of hospital-based PAs remained relatively stable. However, the distribution of PAs within hospital settings has changed, from fewer PAs in hospital-based outpatient clinics to more PAs in inpatient service roles. While PAs employed in the surgical subspecialties increased from 7.7% in 1981 to 21.7% in 1993, PAs employed in hospital settings ranged between 28% and 31.3% (Table 2). By 1992, 48.6% of practicing PAs indicated at least some inpatient care responsibility.[49] In many teaching hospitals, a combination of residency program retrenching, curtailed availability of international medical graduates, and cost-control measures has contributed to expanded inpatient roles for PAs. As a result, PA use in inpatient care roles in a wide variety of hospital settings has become commonplace.

A recent study of 1690 hospital-based PAs revealed that 45% held the job title of or were identified as "house officers." More than 90% had formal medical staff privileges and were credentialed under hospital bylaws. Their practice distribution included 19.4% in surgical subspecialties, 18.6% in medical specialties, 14.8% in emergency medicine, and 9.5% in general surgery.[48] Although the study was inconclusive in determining the levels of resident physician/house officer substitution performed by hospital-based PAs, the authors recognized the need for additional PA education in liability protection and risk management and additional research in levels of responsibility, outcomes, and privileging issues.

PAs and Managed Care

The increasing management by for-profit corporations and the economies of scale realized by capitated managed care organizations require careful cost-benefit considerations in provider ratio and distribution decisions. However, many variables contribute to differing levels of PA role and distribution settings within managed care organizations. Although managed care PAs assume a range of duties in a variety of clinical settings, it appears that physician attitudes toward PAs play a major role in staffing decisions; thus, midlevel provider distribution among similar settings within the same organization can differ significantly.[43]

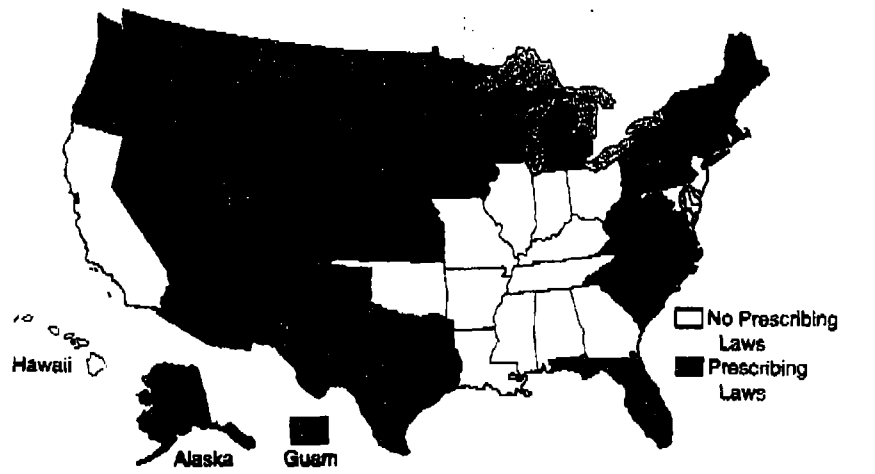
In ambulatory managed care settings, PAs have been shown to be capable of handling approximately 80% of the health care services required to manage patient problems at physician-equivalent levels of patient satisfaction and quality of care.[49] This finding is consistent with observations made in rural private practices, urban ambulatory care clinics, and geriatric settings.[19] In a large group-model health maintenance organization, physicians and PAs were found to see a similar number and type of adult ambulatory patients on an hourly, daily, and annual basis, and PAs were employed at approximately 50% of physician costs.[40] However, additional and more recent data are needed to determine frequency and appropriateness of PA consultation and referral activities, prescribing habits, rate and frequency of patient return visits, comparable degrees and mix of patient difficulty, and the amount of "nonbillable" physician time spent in consultation and supervision of PAs within such settings. In the absence of these data, the evidence indicates that, in organized ambulatory care practices where team approaches and structured division of staffing are present, PA clinical productivity compares favorably with that of physicians.[49]

BARRIERS TO PA PRACTICE

In 1993, PAs were recognized as health care providers by the medical licensing boards of 49 states and the District of Columbia; Mississippi is the only state that does not recognize PAs. State legislative and regulatory agencies maintain control over the patterns of utilization of PAs through their authority to license and regulate the profession. Barriers to enhancing the use of nonphysician health care providers were recently reported as professional territorialism, licensure restrictions, educational isolation, physician resistance, and institutional inertia.[3] These barriers vary geographically, as well as between and among differing nonphysician provider professions. As a means of reducing these barriers and encouraging change in health care delivery, the Office of the Inspector General called for an increased emphasis on supervisory and management skills in curricula for health care educational institutions and the development of cooperative practice models among different health care professions. A combination of population demographics and regulatory and reimbursement policies appears to have the greatest influence on PA practice favorability, particularly in states with disproportionate rural or medically underserved communities. However, current data that more clearly define regional and national barriers to PA practice are needed if health system reform plans include an increased use of PAs.

PA Supervision

The physician-PA employment relationship has been and is intended to remain a dependent one. The fundamental elements of PA practice (use of a referral system, frequent consultation, and periodic review) are said to be synonymous with a well-designed health system.[50] The PA's ability to consult with and refer to the supervising physician is the key factor to a successful workplace relationship, and studies suggest that the task delegation and supervision behaviors of the physician have the greatest influence on PA clinical productivity.[51] Geographic practice isolation in rural and frontier



Physician assistant prescribing authority, 1993.

settings may by necessity result in varying degrees of off-site physician supervision of the PA, and this physical separation requires a certain amount of autonomous judgment, particularly when the PA is the only available on-site provider. Regulatory reluctance to support such relationships in satellite and remote settings restricts the ability of PAs to provide needed services that might otherwise be unavailable.

Prescriptive Authority

A total of 35 states, the District of Columbia, and Guam authorize PAs to prescribe medications, but a nucleus of states do not. The cluster of 12 states (Figure) represent approximately 37% of the total US rural health professional shortage areas.[52] Although prescriptive authority varies from state to state and ranges from using protocol-based formularies for noncontrolled substances to prescribing controlled substances, PA prescribing must be done with the agreement and supervision of the physician. Patterns observed in rural PA practice in Texas reveal an example of the potential effect of prescriptive authority to increase the capabilities of PAs to improve access to care. Prior to PA prescriptive legislation passed in 1991, Texas had 26 rural health clinics. By November 1992, the number had nearly quadrupled, increasing to 99. During the same period, the percentage of Texas PAs practicing in rural areas tripled, from 5% to 15%.[53,54]

Reimbursement Issues

Variation in state laws regarding compensation for PA-provided services has also influenced PA deployment. For example, successful implementation of the Rural Health Clinic Services Act (Public Law 95-210), which provides for criteria-specific Medicare and Medicaid reimbursement for PA services, is hindered in some states by variations in the scope of their practice laws governing PAs. The practice of PAs is also complicated by state-by-state Medicaid reimbursement policies that remain inconsistent. The services of PAs are governed by the "incident to" provision, which allows for reimbursement at the physician fee level for office or clinic services provided by the physician's staff that are considered integral, although incidental, to the physician's services. The physician must be present when the PA-performed services are delivered, and the PA's services are billed and paid for as if the physician had performed them. Differing states' interpretations of the incident to physician service clause of Medicare and its carriers confuse PA employers regarding reimbursement for services provided by PAs, especially where on-site supervision is not always required, and where PAs are hired by practices for the specific purpose of extending medical services to rural and underserved communities.

Although Medicare reimburses 100% of the physician fee schedule for PA services provided incident to a physician's service, reimbursement rates for other services provided by the PA are lower. Furthermore, these rates often vary, depending on the site of the services. For example, reimbursement for PA services performed in a nursing facility may not exceed 85% of the physician rate; in a hospital setting it may not exceed 75% of the physician rate; PA-assisted surgery reimbursement may not exceed 65% of the physician rate. Medicare services rendered by PAs are always reimbursed to the PA's employer; thus, these variables must be considered when determining the most cost-effective use of PAs.

PAs AND HEALTH SYSTEM REFORM

The roles to be assumed by PAs in the forthcoming health system reform initiatives are yet to be determined. Because PA education so closely resembles a condensed version of medical school, many of the same factors that complicate physician education and distribution are similarly experienced by the PA profession.

The argument that increasing existing PA program enrollment is less expensive than developing completely new programs must be tempered with the realities of increasing institutional competition for fixed educational resources. For example, AHCs with both a medical school and a PA program may not be able to absorb the added expense, space, and time requirements of more lecture commitments by basic science faculty, resident physicians, and staff attendings; more classroom space; and more competition for already limited teaching time on ward rounds, in the clinics, and in operating rooms. Additionally, the simultaneous demand to produce more generalist physicians may increase competition among medical schools, residency programs, and PA programs for sites for quality primary care clinical education. President Clinton's Health Security Act includes favorable provisions affecting PAs, but many questions relating to the prospective roles for PAs remain unanswered. The Health Security Act does not specify how the annual $400 million allocated for primary care education among medical schools, nursing schools, and PA programs is intended to be distributed.

Although a number of proposals suggest differing roles for midlevel providers within the context of health system reform,[1,3,4,5,55,56] the fact remains that PAs are inextricably dependent on physicians for their employment and supervision. The position stated by the American Boards of Family Practice and Internal Medicine opposing independent practice by nonphysician professionals also reflects the position of the PA profession.[56] The American Academy of Physician Assistants reaffirmed that the PA profession does not seek independent practice, direct reimbursement from third-party payers, or federal preemption of state practice acts.[57] Nevertheless, if health system reform initiatives include a greater role for PAs in the provision of health care, greater efforts must be made to improve the linkages and relationships between and among PA programs, medical schools, and generalist physician residency training programs. Introducing more medical students and

residents to the roles, functions, and capabilities of the physician-PA team in educational settings might reduce the existing degree of reluctance to "work together in well-integrated teams to enhance the quality and availability of cost-effective patient care," as called for by the American Boards of Family Practice and Internal Medicine.[56(p115)]

While the PA profession acknowledges the importance of working closely with physicians, the trend of increasing specialty practice of PAs is a topic of ongoing debate between generalist and specialty PAs.[58-60] Some generalist PAs are critical of the splintering effect of professional alignment with specialty groups, whereas some specialty PAs berate their reluctance to expand with the job market. Notwithstanding the specialty vs primary care rift within the PA profession, national health system reform measures will help determine whether PAs will continue to gain acceptance and legitimacy. Although the PA profession is faced with several obstacles to growth and expanded provider roles, success or failure in a changing environment will be sured by the profession's ability to the needs of the medical marketplace.

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I also though it might be helpful to address a couple of issues of professional sensitivity:

- First, the correct legal title of the profession is physician assistant -- not physician's assistant or physicians' assistant. A physician's assistant could be any individual who provides assistance to a doctor, including front office staff.

- Second, there are numerous differences between the PA and nurse practitioner education programs, certification procedures, and their scopes of practice. A major difference is in the importance PAs place on the team approach to health care by practicing with physician supervision. Talking about the two professions collectively -- as "mid-level providers" or "physician extenders" -- insinuates no philosophical or professional differences between the two. Many PAs don't work like nurses and many NPs don't work like PAs.

- Third, PAs have been compared to family nurse practitioners (FNPs) because the two professions are educated to handle patients from birth to death. It is incorrect to compare PAs to clinical nurse specialists, geriatric or pediatric nurse practitioners, nurse midwives, or in general to "advanced practice nurses" because these nurse specialists have received an education limited to specific age groups or diseases.

The program on May 25th is scheduled to go as follows:

10 a.m. Central Time -- Ann Elderkin, National President, AAPA, will call the General Session to order and discuss what AAPA has been doing in Washington, DC, and throughout the country concerning health care reform. She also will mention the visits she has made to the White House (for two Rose Garden ceremonies) and the meetings PAs and AAPA staff have had with the Health Care Task Force members and White House staff. Judith Feder was a guest speaker at a national AAPA leadership conference in Alexandria, VA, last fall.

10:10 a.m. -- Elderkin will explain the satellite feed, how the Q&A session will work and introduce Mrs. Clinton

10:15 a.m. -- (God and modern technology willing) Mrs. Clinton will address the 3,000 or so PAs attending the conference

10:30 a.m. or so -- Mrs. Clinton will conclude her remarks and ask Ann Elderkin if there are any questions from the audience

10:35 to 10:45 a.m. -- Elderkin and other PAs will read questions that have been submitted by the physician assistants attending the conference

(more)

10:45 a.m. -- Elderkin will thank Mrs. Clinton for taking the time to address the PAs and the satellite will go dark. We are considering reserving 45 minutes on the satellite (in case there are problems at the beginning or end of the transmission), so the Q&A may run a few minutes after 10:45, if that's OK.

10:50 a.m. -- Elderkin will introduce Ernesto Gomez, CEO of El Centro del Barrio, a series of health care clinics for low-income and homeless people. AAPA is presenting to Gomez a check for $5,000 to help underwrite Centro's immunization program which has served tens of thousands of low-income San Antonio children since 1980.

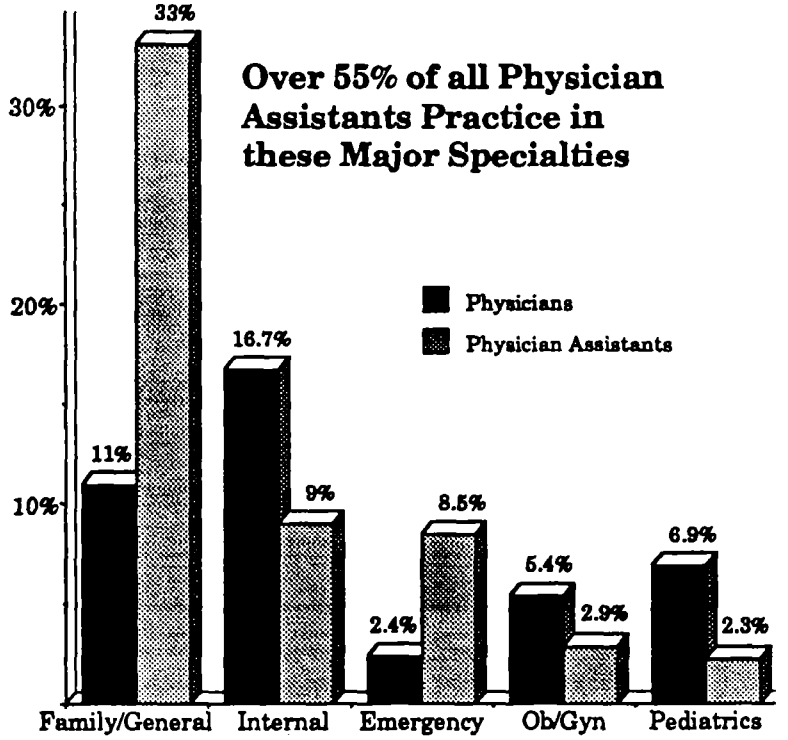
11 a.m. -- Reports from various PA leaders

11:30 a.m. -- General Session adjourns

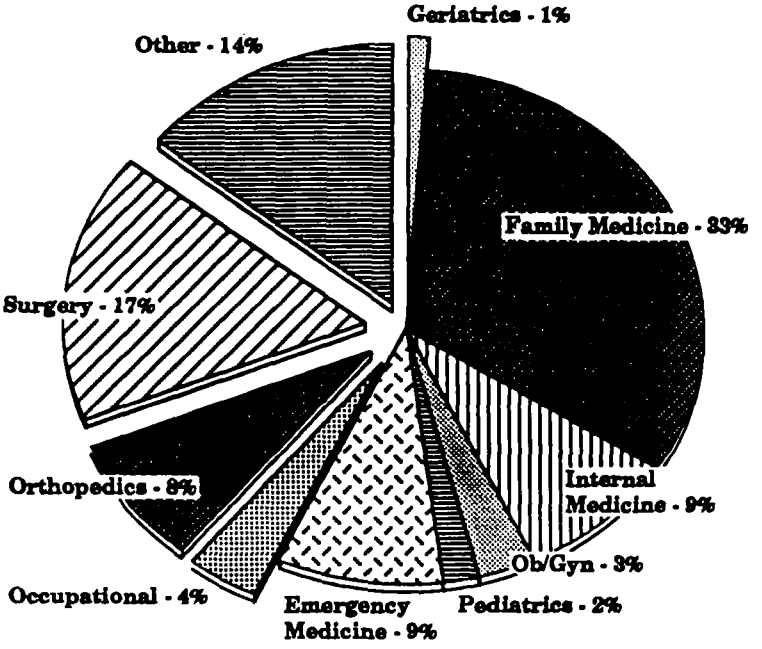
If you should have any questions concerning the arrangements for Mrs. Clinton's presentation or about the AAPA Conference in general, please call me or Nancy Hughes, AAPA Public Affairs Administrator, at the Marriott Rivercenter -- 210-223-1000 -- or at the AAPA Convention staff office -- 210-270-2973/2972.

Physician Assistants: PArtners in Medicine

- Physician Assistants (PAs) practice medicine with the supervision of licensed physicians.
- Of the 27,000 PAs who have been trained, approximately 23,500 are currently in clinical practice (87%).
- PAs are educated in a medical program and are qualified to treat approximately 80% of the patients seen by primary care physicians.
- PAs can write prescriptions in 37 states and the District of Columbia.
- Seventeen percent (17%) of all PAs practice in rural communities with fewer than 10,000 people; 34% in towns with fewer than 50,000 people.
- Seventy percent (70%) of all PAs practice in outpatient settings (clinics, HMOs, medical offices).
- PA distribution more closely matches the population than other primary care providers.
- There are 58 specially designed PA training programs located at medical colleges and universities, teaching hospitals and through the Armed Forces. The programs are accredited by the American Medical Association's Committee on Allied Health Education and Accreditation.
- A typical PA student has a bachelor's degree and over 4 years of health care experience prior to admission.



Source: Physician Characteristics and Distribution in the U.S., 1993, American Medical Association, and 1993 Census, American Academy of Physician Assistants (AAPA). AAPA includes emergency medicine when discussing primary care because of the large number of people rely on hospital emergency rooms for services.



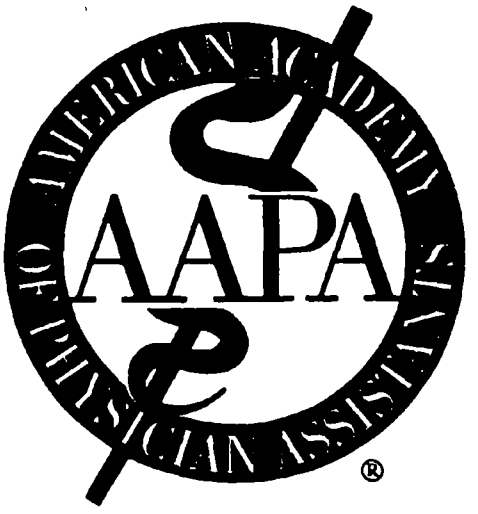
Over 50% of all Physician Assistants Provide Primary Care Services

- PA education is typically 24 months in length representing approximately two-thirds that of medical students (102 compared to 153 weeks).
- Nearly all states require PAs to pass a national certifying examination administered by the National Commission on Certification of Physician Assistants (NCCPA).
- To maintain certification, all PAs must complete 100 hours of continuing medical education every two years, and take a recertification exam every six years, the only major health profession with such a requirement.
- According to the Congressional Office of Technology Assessment, "within the limits of their expertise, PAs provide care that is equivalent in quality to the care provided by physicians."
- Studies conducted by the RAND Corporation have found that PAs save as much as 20% of the costs of medical care, can perform 80% of the routine functions of a physician's practice, and are widely accepted by patients.
- Case law reveals that PAs have been involved in very few malpractice suits.
- Current national statistics indicate approximately six (6) jobs for every new PA graduate. The Department of Labor projects the number of PA jobs will grow by 44% from 1990 through 2005.

American Academy of Physician Assistants
950 N. Washington St., Alexandria, VA 22314
(703) 836-2272

Official Definition of
Physician Assistant

approved by the
American Academy of Physician Assistants (AAPA)
House of Delegates
May 1991



"**Physician assistants (PAs)** practice medicine with supervision by licensed physicians. As members of the health care team, PAs provide a broad range of medical services that would otherwise be provided by physicians.

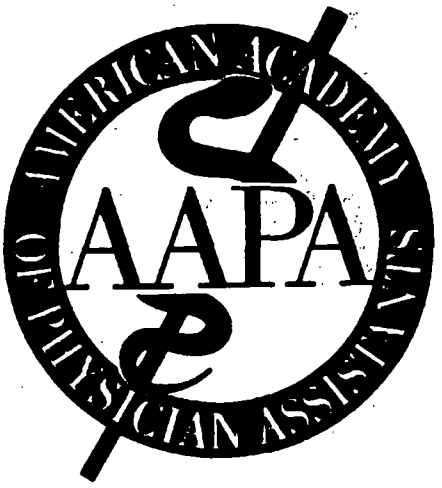
It is the obligation of each team of Physician/PA to ensure that the physician assistant's scope of practice is identified; that delegation of medical tasks is appropriate to the physician assistant's level of competence; that the relationship of, and access to, the supervising physician is defined; and that a process of performance evaluation is established. Adequate and responsible supervision of the PA contributes to both high quality patient care and continued professional growth.

The AAPA is committed to the concept of physician assistant practice of medicine with supervision by licensed physicians."

HOD 1303-01-01
7-26-93

AAPA

Physician Assistants:



PArtners in Medicine

PHYSICIAN ASSISTANTS

BACKGROUND

Physician assistants (PAs) practice medicine with supervision of licensed physicians, providing patient care services that would otherwise be performed by physicians.

Overview

The relationship between a physician and a physician assistant (PA) is one of mutual trust and reliance. The PA's responsibilities depend on the type of practice, his or her experience, the working relationship with the physician and other health care providers, and state laws.

Educated in a medical program, PAs are qualified to perform approximately 80 percent of the duties most commonly done by primary care physicians. PAs perform physical examinations, diagnose and treat illnesses, order and interpret lab tests, suture wounds, set fractures, and preform minor surgery. In a majority of states, PAs write prescriptions.

PAs Practice Medicine

Physician assistants follow a medical model of patient care and practice medicine with supervision by licensed physicians. PAs perform a wide range of medical duties, from basic primary care to high-technology specialty procedures. Specific duties are defined by state regulation and practice setting, but include both diagnostic and therapeutic procedures. PA education also prepares physician assistants to deal with many medical emergencies. PAs often act as first or second assistants in major surgery, and provide pre- and post-operative care.

In some rural areas, where physicians are in short supply, PAs serve as the only providers of health care, conferring with their supervising physicians and other medical professionals as needed and as required by law.

Education

PAs are educated in one of 58 specially designed PA programs located at medical colleges and universities, teaching hospitals, and through the Armed Forces. Due to the close working relationship PAs have with physicians, PA education was designed to complement that of physicians.

PA programs generally require applicants to have at least two years of college education and previous experience in health care. The typical PA student in 1992 had a bachelor's degree and over 4 years of health care experience prior to admission to the PA program. PA education is usually 24 months in length and is approximately two-thirds that of medical students (102 weeks compared to 152). PAs take some of the same classes with medical students.

The first phase of PA education is in the classroom, providing students with an in-depth understanding of medical sciences. Additional subjects include differential diagnosis, medical ethics, and pharmacology. The second year is spent in clinical rotations. Each year, PA programs graduate approximately 1,700 men and women. The majority of all PA programs offer a baccalaureate degree upon completion; twelve have master's degree programs or master's options.

Practice Credentials

Nearly all states require PAs to pass a national certifying examination before they can begin practicing. The exam, open only to graduates of accredited PA programs, is given each year by the National Commission on Certification of Physician Assistants (NCCPA), an independent organization established to assure the competency of PAs.

To maintain certification, PAs must complete 100 hours of continuing medical education every two years and take a recertification exam every six years. Only those with current certification can use the credentials Physician Assistant-Certified or "PA-C."

Practice Settings

Today there are over 27,000 PAs in the United States; over 40% of all practicing PAs are women. PAs practice in almost all health care settings and every medical and surgical specialty. They also serve on the White House medical staff.

Seventeen percent of all PAs practice in rural communities with fewer than 10,000 people; a third practice in towns with fewer than 50,000 people. The majority of all PAs (57%) practice primary care, with 33% in family medicine. Seventeen percent practice in surgical specialties. Approximately 70% of all PAs practice in outpatient settings (clinics, HMOs, medical offices), and 30% practice in inpatient settings (hospitals).

Growth of the PA Profession

Demand for PA services is rapidly increasing. Current national statistics show there are approximately six jobs for every new PA graduate. The Department of Labor projects the number of physician assistant jobs will grow by 44% percent from 1990 through the year 2005.

Factors that have contributed to this growth include Medicare/Medicaid reimbursement for PA services and increased recognition of the quality of care that PAs provide.

• • • •

"Conceived during the new health practitioner movement of the 1960s, physician assistants have demonstrated their clinical effectiveness both in terms of quality of care and patient acceptance."

— Eighth Report to the President and Congress on the Status of Health Personnel in the United States

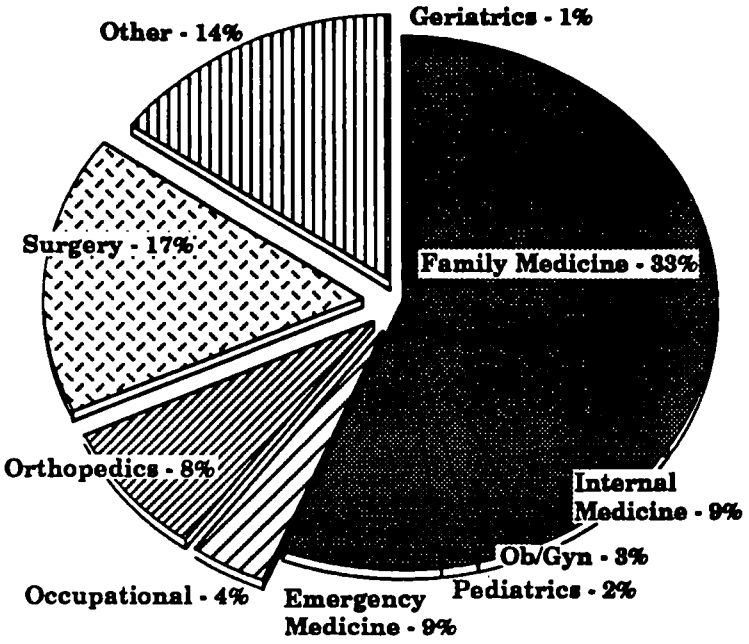
Practice Settings

Physician assistants (PAs) practice medicine with the supervision of licensed physicians, providing patients with services ranging from primary medicine to very specialized surgical care.

Currently there are over 27,000 physician assistants in the United States, nearly double the number just ten years ago. In some rural areas, where physicians are in short supply, PAs serve as the only providers of health care, conferring with their supervising physicians as needed or required by law.

While most physician assistants are in primary care settings such as a family practice, PAs also are filling roles that were not anticipated when the profession began. Some of these practice settings include nursing homes, HMOs, and occupational medicine. Many hospitals, faced with a shortage of physician residents, have discovered the value of physician assistants. PAs even serve on the White House medical staff. Physician assistants practice in nearly all medical and surgical specialties.

The PA profession has demonstrated its ability to adapt to a constantly changing health care environment. Having become an integral part of health care delivery, it is likely that PAs will continue to find, and fill, new and expanding roles in health care.



Most Physician Assistants Practice Primary Care Medicine

In 1993, 17 percent of all physician assistants worked in rural communities with fewer than 10,000 residents. Twenty percent practiced in cities with more than a million people. Fifty-seven percent of all PAs practice primary care, which AAPA defines as including family medicine, internal medicine, pediatrics, geriatrics, obstetrics and gynecology, and emergency medicine.

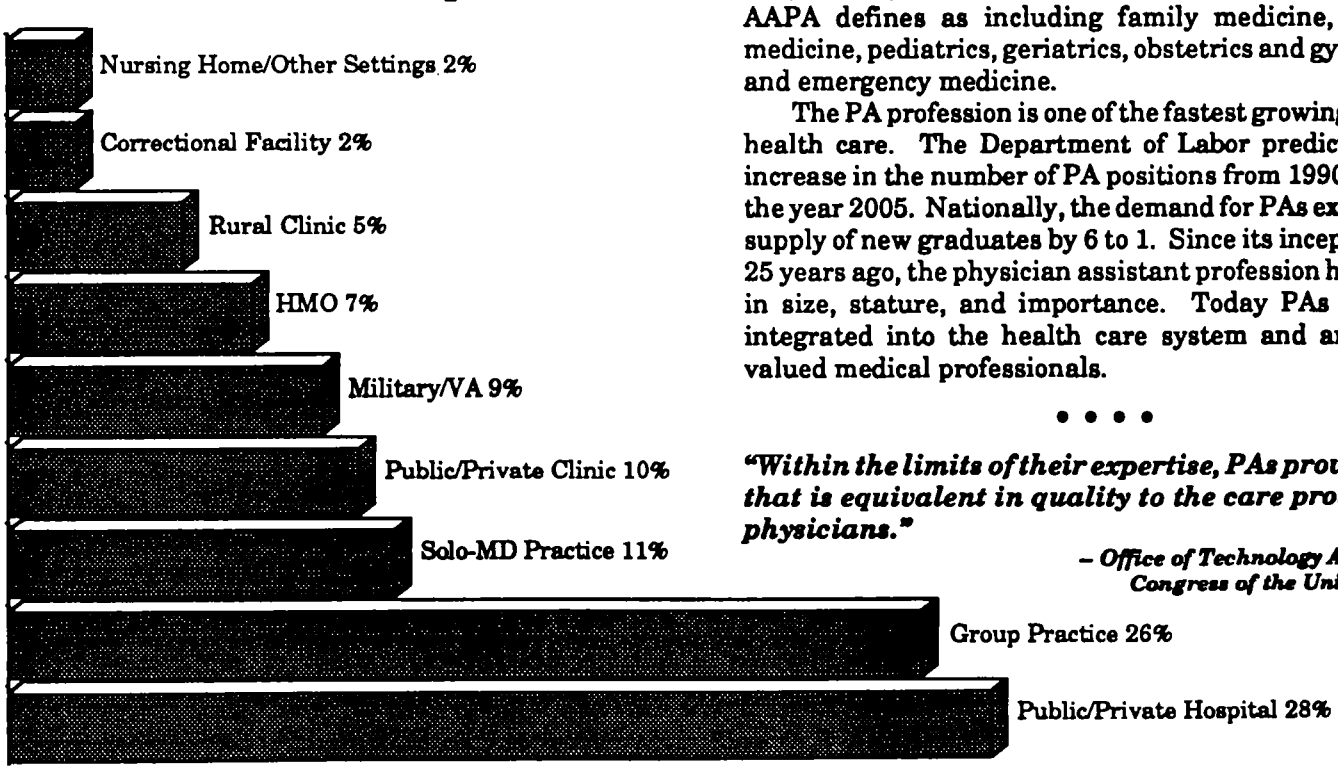
The PA profession is one of the fastest growing fields in health care. The Department of Labor predicts a 44% increase in the number of PA positions from 1990 through the year 2005. Nationally, the demand for PAs exceeds the supply of new graduates by 6 to 1. Since its inception over 25 years ago, the physician assistant profession has grown in size, stature, and importance. Today PAs are fully integrated into the health care system and are highly valued medical professionals.

• • • •

"Within the limits of their expertise, PAs provide care that is equivalent in quality to the care provided by physicians."

– Office of Technology Assessment Congress of the United States

Approx. 70% work in outpatient settings (clinics, HMOs, medical offices) and 30% in hospitals



PHYSICIAN ASSISTANTS

EDUCATION

PA education was modeled after physician's training -- including continuing medical education to keep abreast of medical advances.

Overview

Physician assistants are trained in an intensive medical education program that usually lasts 24 months in length. The program is offered at medical schools, colleges and universities, teaching hospitals, and through the Armed Forces. Because of the close working relationship between physician assistants and physicians, PA education was modeled after physician's training and is similar in structure, albeit shorter than medical school. Physician assistants often attend the same classes with medical students.

The first year is composed of classroom instruction, with a heavy emphasis on medical sciences and related disciplines. Second-year PA students perform clinical rotations, seeing and treating patients. Some programs offer specialty training.

The Students

The typical PA student in 1992 had a bachelor's degree and over 4 years of health care experience prior to admission to a PA program. Fifteen percent of all physician assistants were nurses, 14% were emergency medical technicians, 13% were medics, and 9% were emergency room technicians before they became PAs. There is fierce competition to get into a PA program. In 1992, PA programs turned away five qualified applicants for every student accepted.

The Programs

There are 58 physician assistant programs in the United States, graduating approximately 1,700 PAs a year. Programs are accredited by the American Medical Association's Committee on Allied Health Education and Accreditation (CAHEA). Only graduates of accredited PA programs are eligible to take the national certifying examination.

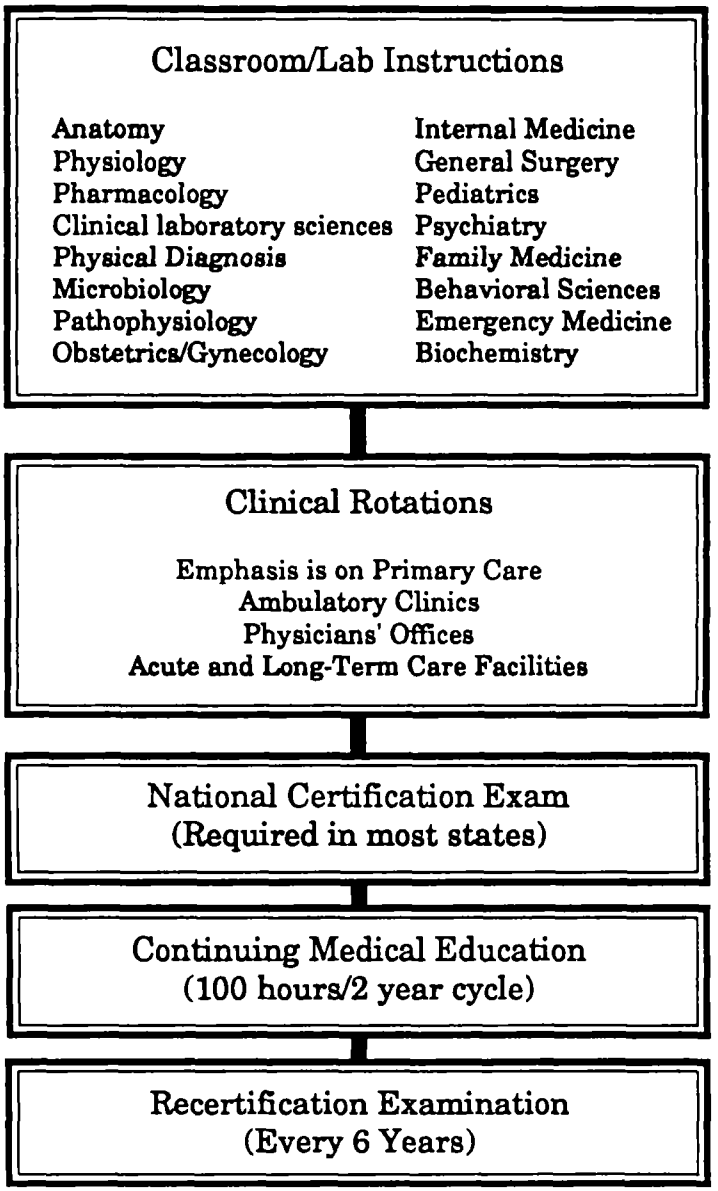
National Certification

Most states require PAs to pass the national certification examination, offered by the National Commission on Certification of Physician Assistants (NCCPA). Only those successfully completing the examination may use the credentials "Physician Assistant-Certified" or "PA-C."

A PA's education does not end at graduation. In order to remain certified, physician assistants are required to complete 100 hours of continuing medical education (CME) every two years and take a recertification examination every six years. It is the only major health profession with such a requirement.

Degrees Awarded

All PA programs offer a certificate upon graduation; most offer a bachelor's degree. Twelve of the programs also have a master's degree program or master's options. More than 70% of all physician assistants have a bachelor's degree, and an additional 12% have a master's degree or higher.



• • • •

"Since the inception of the discipline in the 1960s, physician assistants have become firmly established as a provider group well suited to address problems of maldistribution of physicians and enhancing cost-effectiveness in health care."

– Eighth Report to the President and Congress on the Status of Health Personnel in the United States

PAs IN THE US

In 1967
The physician assistant concept originated during the mid-1960s. Physicians and educators recognized there was a shortage and uneven distribution of primary care physicians. To combat these problems, the physician assistant program was developed. The first physician assistants graduated from Duke University in 1967. They were former Navy corpsmen who wanted to use their medical skills in civilian life.

Today
A majority of all PAs provide primary care, and 33% practice in towns with fewer than 50,000 residents. PA distribution more closely matches the population than other primary care providers according to the *Seventh Report on the Status of Health Personnel in the United States*, published by the U.S. Department of Health and Human Services in 1990. The report noted that, were it not for PAs, many areas would have little or no access to quality health care.

The PA Practice
Physician assistants work in all 50 states, the District of Columbia, Guam, and around the world in the military. In 1992, there were approximately 152 million patient visits to physician assistants.

The median salary range for clinically practicing physician assistants nationwide is $50,000 to $55,000, which is approximately half the average salary of a family physician.

All PAs must, by law or regulation, have a supervising physician. It is not necessary, however, for the physician and PA always to be located in the same building or even the same town. Most state laws allow the supervising physician to be away from the practice when the PA is seeing patients.

• • • •

"(Congress has) singled out programs in family medicine, general internal medicine, and general pediatrics, and training of physician assistants. . . for priority in the allocation of federal assistance because these professions will play a pivotal role in reaching the national goal of making access to primary health care more widely available and of reducing unnecessary health care costs."

–United States Congress, 1992
Public Law 102-408

Quality Care
A study by the Congressional Office of Technology Assessment concluded that "within the limits of their expertise, PAs provide care that is equivalent in quality to the care provi by physicians." Studies conducted by the Rand Corporation and others found that PAs save as much as 20% of the costs of medical care, can perform 80 percent of the routine functions of a primary care physician's practice, and are widely accepted by patients.

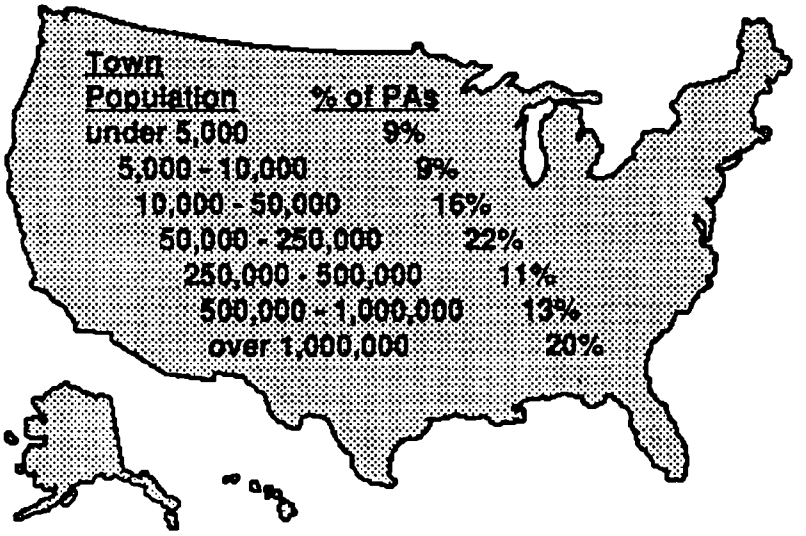
Case law reveals that physician assistants have n involved in very few malpractice cases. The majority of PAs are insured by a rider on their employer's malpractice policy; many have their own coverage.

Prescribing
A PA's practice is determined by education and experience, the supervising physician's practice, and state law. One aspect of state law is prescriptive authority.

During the last decade, the number of states granting prescriptive authority has more than doubled. Thirty-seven states, the District of Columbia, and Guam allow PAs to write prescriptions for medications.

Prescriptive practice for physician assistants is a logical outgrowth of both their role and education. PA education in pharmacotherapeutics (the study of the use of medication in the treatment of disease) is proportionally equivalent to that of physicians. The National Board of Medical Examiners determined that the PA national certification examination is a valid assessment of this knowledge. Surveys show a strong similarity between PA and physician prescribing patterns.

A state-by-state summary of the laws and regulations governing PAs is available from the American Academy of Physician Assistants.



ORGANIZATIONS

American Academy of Physician Assistants

The American Academy of Physician Assistants (AAPA) is the national professional society for PAs. Founded in 1968, the Academy has chapters in all 50 states, the District of Columbia, and Guam. There are also chapters that represent physician assistants working for the Public Health Service, the Department of Veterans Affairs, and all branches of the military.

The mission of AAPA is to "promote quality, cost effective, and accessible health care and to promote the professional and personal development of PAs." Major activities to accomplish this goal include government relations, public education, research and data collection, and professional development.

Eighty percent of all practicing physician assistants are members of AAPA. Members are graduates of accredited physician assistant programs and/or those who are nationally certified. Students at accredited programs are also eligible for membership.

The AAPA's Physician Assistants Foundation (PAF) provides funds for scholarships and research on the PA profession. In 1992, it awarded 37 scholarships totalling $87,000 to PA students and $15,000 in research grants to AAPA members.

For more information, contact:
American Academy of Physician Assistants
950 North Washington Street
Alexandria, VA 22314
(703) 836-2272

National Commission on Certification of Physician Assistants

The National Commission on Certification of Physician Assistants (NCCPA) is an independent organization established to assure the competency of physician assistants. The NCCPA was formed in 1975 by AAPA and other health professional associations in order to administer a national certifying examination to graduates of accredited PA programs. The examination and the recertification exam physician assistants are required to take every six years are designed to test the medical knowledge and clinical skills of PAs.

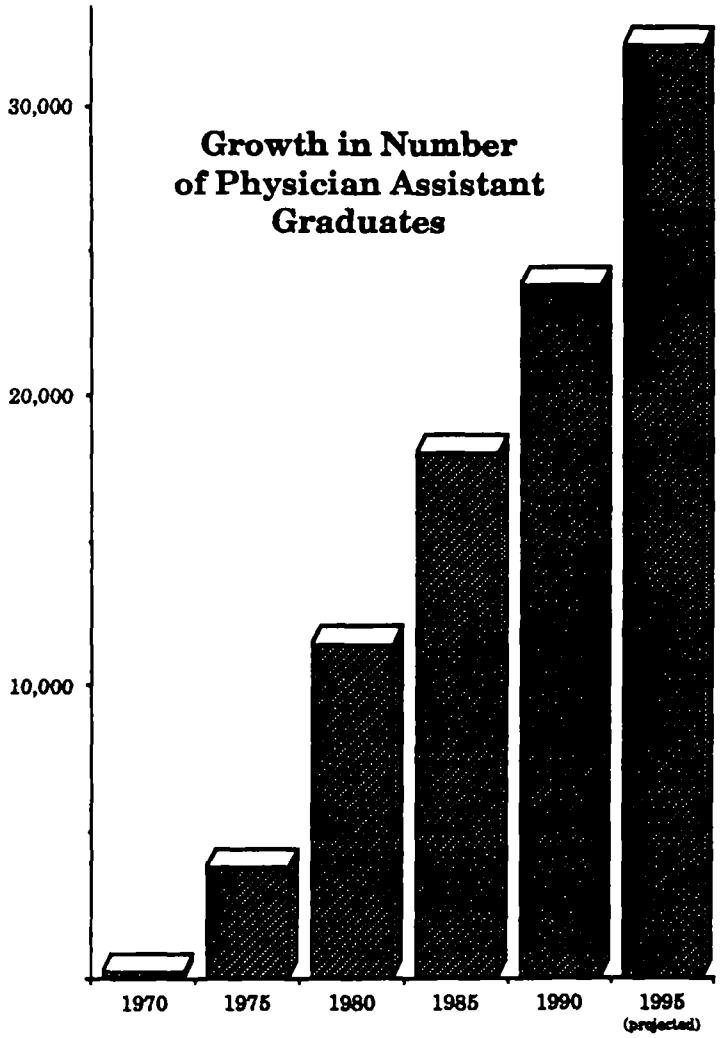
For more information, contact:
NCCPA
2845 Henderson Mill Road NE
Atlanta, GA 30341
(404) 493-9100.

Association of Physician Assistant Programs

The Association of Physician Assistant Programs (APAP) shares its national headquarters with AAPA. Whereas the Academy is made up of graduates and students, APAP members are the physician assistant educational programs and faculty. Founded in 1972 to help maintain the high quality of PA education, APAP's objectives are to encourage communication among the programs and to serve as a national information center on PA education.

APAP publishes the "National Directory of PA Programs," giving complete information on the names, locations, requirements, tuition, length, and degree(s) awarded for each of the accredited PA programs. The directory is available to the public for a small fee.

For more information, contact:
Association of Physician Assistant Programs
950 North Washington Street
Alexandria, VA 22314
(703) 548-5538



NATIONAL HEALTH CARE REFORM

President Clinton's health reform legislation, the "Health Security Act" (HR 3600, S 1757), seeks to provide quality health care to all Americans, including millions of individuals who are currently uninsured or underinsured. To accomplish this goal, the bill recognizes physician assistants (PAs) as qualified health care professionals who provide essential, cost-effective health care.

▲ **Health care teams**

By defining "health professional services" to include physicians and others legally authorized to provide services, the legislation recognizes that physician assistants provide quality health care that should be available to all Americans under health care reform. PAs are included in the definition of "lawful health care provider" whose services must be covered under any fee-for-service plan offered by a regional alliance.

PAs are specifically listed in the definition of health professionals who may be considered "essential community providers" eligible for certification. Health plans would be required to contract with institutions, agencies and providers certified as essential community providers in order to assure that underserved populations have access to care.

▲ **Increased funding for PA education**

Authorized spending has been set at $400 million to cover "primary care physician and physician assistant training," plus programs for the training of underrepresented minorities and nurses. The American Academy of Physician Assistants (AAPA) seeks specific earmarking of funds for PA educational programs.

The legislation changes the financing of graduate medical education. Rather than coming entirely from the Medicare trust fund, physician residency training would also be supported by money set aside from private health insurance premiums collected by corporate and regional alliances. In a precedent-setting move, the bill allots $200 million of these funds for graduate nurse education. The AAPA believes that PA education programs should also be eligible for GME funds, which is a steady source of financial support immune from discretionary spending caps and the annual appropriations process.

▲ **Enhancement of PA practice environment**

The legislation recognizes that physician assistants are essential to the delivery of primary care and preventive services, particularly if all Americans are to have access to quality health care. It includes language encouraging and supporting full utilization of the "professional education and clinical skills of advanced practice nurses and physician assistants."

Within the Department of Health and Human Services, programs are authorized to encourage the adoption of model professional practice statutes for PAs and to support the removal of inappropriate barriers to practice. The AAPA seeks the addition of language directing the Secretary of HHS to consult with the appropriate professional society on the issue of a model law.

The Health Security Act does not provide for a federal preemption of restrictive state practice acts. Rather, it declares that "No state may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals." The AAPA supports the removal of unnecessary practice restrictions, but does not believe the federal government should override state laws.

▲ **Increased access for Medicare beneficiaries**

The legislation amends existing law and extends Medicare coverage for outpatient physician services provided by PAs from rural Health Professional Shortage Areas to all geographic areas. Reimbursement would be paid to the PA's employer at 85 percent of the physician's fee. This provision is essential and must be included in any health care reform legislation enacted by Congress.

▲ **Support for providers in underserved areas**

The bill increases funding for the National Health Service Corps ($50 million in FY95, $100 million in FY96, and $200 million for each of fiscal years 1997 to 2000). The AAPA recommends replacing the bill's proposed requirement that 20 percent of all NHSC participants be nurses with language doubling the current 10 percent set-aside of scholarship and loan repayment awards for PAs, nurse practitioners and nurse midwives.

The Health Security Act contains a $500 per month personal tax credit for primary care physician assistants practicing full-time in Health Professional Shortage Areas. The AAPA recommends modification of the recapture provisions for PAs unable to complete the 60-month mandatory service period and extension of this credit to PAs working in underserved areas prior to 1995. The AAPA recommends the extension of the tax credit beyond five years.

The AAPA also recommends that Medicare bonus payments, currently available only to physicians, be authorized for PAs working in underserved areas.

▲ **Miscellaneous provisions**

The legislation authorizes $200 million for skill enhancement and retraining programs to be administered by the Department of Labor. These include retraining health care workers for more advanced positions as technicians, nurses, and physician assistants.

The Health Security Act would establish a National Council on Graduate Medical Education, a National Council on Graduate Nurse Education, and a National Institute for Health Care Workforce Development. The AAPA recommends that Congress consider consolidation of these functions to avoid unnecessary bureaucracy and to achieve more effective workforce planning and administration.

AAPA National Health Reform Policy

The American Academy of Physician Assistants believes that a national health care program should provide basic health care services to all residents and that the scope of such services should be determined by public policy and be based on considerations such as medical effectiveness. Health care services should be provided by qualified persons who practice a team approach to care. Patients should retain a choice of providers and be satisfied with the quality of care offered by the providers and the health care system.

In addition, AAPA believes that the structure of a national health care program should be determined by the federal government, and administered by the states under national guidelines. Financing mechanisms should be fair, equitable, and include cost controls.

The AAPA advocates a national health care program based on these principles because the existing fragmented system inhibits access and is inherently inflationary. Only a well-managed national health care program can guarantee universal access and moderate health care expenditures.

AAPA Position on the "Health Security Act"

Therefore, to the degree that the President's "Health Security Act" meets these principles, the American Academy of Physician Assistants can support the proposal. The AAPA applauds the bill's focus on universal access and comprehensive primary and preventive care services; its emphasis on a team approach to health care delivery; its attention to research on effective medical procedures; and its preservation of the patient's right to choose his or her health care provider.

5/94

The American Academy of Physician Assistants ▲ 950 N Washington St ▲ Alexandria, VA 22314

690
543

Work: 617-625-6600 x4300
after 4:30:
617-625-6875

Where's Statement

American Academy of Physician Assistants
950 North Washington Street, Alexandria, Virginia 22314
(703) 836-2272 FAX: (703) 684-1924

ANN L. ELDERKIN, PA
PRESIDENT 1993-94
AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Ann Elderkin represents one of the fastest growing health care professions in the United States -- physician assistants (PAs).

Physician assistants are medically trained to provide health care services that traditionally have been performed by doctors, including diagnosing illnesses, developing treatment plans, assisting in surgery, and in most states prescribing medication. They practice medicine with the supervision of a physician, yet most state laws provide for supervision to occur via telephonic communications.

In addition to her volunteer duties as president of AAPA, Elderkin is the director of the Health Department in Somerville, Massachusetts. Somerville is a city of 76,000 residents next to Boston. Somerville faces some of the pressing health care issues of today -- AIDS, tuberculosis, smoking, violence, substance abuse, lead paint poisoning, childhood immunizations, elderly health care, and the health problems of those who are under- and un-insured.

Elderkin received her medical training at the Yale University School of Medicine Physician Associate Program and graduated in 1980. Her clinical work has included internal medicine, cardiothoracic surgery, family medicine, and outpatient "urgent care" medicine at Harvard Community Health Plan, one of the largest HMOs in Massachusetts. Elderkin received her bachelor's degree in Human Services Administration from the University of Massachusetts in Amherst in 1976.

Just prior to her appointment as director of the Somerville Health Department in 1990, Elderkin worked as a senior research analyst for the chairman of the State Senate Health Care Committee. She was responsible for analyzing and developing legislation and budget amendments on health care policy and financing issues, including a universal health care law, medical malpractice insurance, and health care cost containment.

In her position as director of the Health Department, Elderkin has been a leader in AIDS education and services. She also has led the effort to pass comprehensive local tobacco control regulations and to implement educational programs to promote non-smoking. She serves on the board of trustees of her local hospital and on the Governor's Advisory Committee on Childhood Lead Poisoning Prevention. Elderkin is a former VISTA volunteer.

"If we are going to truly reform the health care system and do it in a way that will reduce health care costs without reducing quality, then we must consider new ways of delivering that health care." –
Ann Elderkin speaking before the President's Health Care Task Force, Washington, DC. April 2, 1993

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton, Final [partial] (3 pages)	5/25/94	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3986

FOLDER TITLE:
[HRC Daily File] May 25 [1994] Physician's Assistants

2014-0483-S
sb424

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

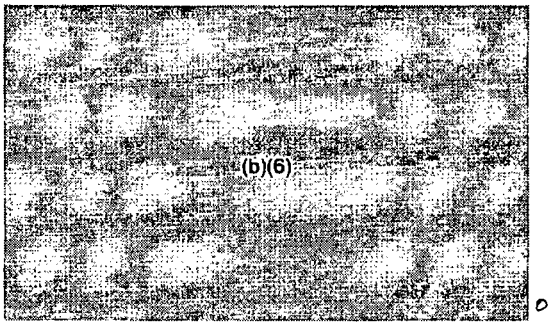
b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

SCHEDULE FOR HILLARY RODHAM CLINTON
DATE: WEDNESDAY, MAY 25, 1994
FINAL

Scheduling Desk:	**Sharon Kennedy**	
	202-456-2922 or 7561	**office**
	202-456-2317	**fax**
	202-544-4223	**home**
	1-800-528-7823	**WHCA#4233**

PREV RON The White House

7:45 am-



001

8:50 am **DEPART** White House South Portico
EN ROUTE Mayflower Hotel
(Drive Time: 5 minutes)
Traveling with HRC:
-Kelly Craighead
-Lisa Caputo
-Bob McNeely

8:55 am **ARRIVE** Mayflower Hotel
1127 Connecticut Avenue
17th and DeSales Entrance

NOTE: Kara McGuire will meet HRC curbside.

Curbside Greeters: Barbara Cochran, CBS News and Co-Chair, IWMF
Kathy Bushkin, U.S. News & World Report and Co-Chair, IWMF

9:00 am-
9:10 am **OFFICIAL PHOTOS**
w/ International Women's Media Foundation Board(IWMF)
Cabinet Room
CLOSED PRESS

PARTICIPANTS: Approx. 17 Board Members
(See briefing book for further info.)

FORMAT:
Official photos/receiving line.

NOTE: WH Photographer will be present.

9:15 am-
10:00 am

INTERNATIONAL WOMEN'S MEDIA FOUNDATION
Grand Ballroom
HRC's Holding room: Chinese Extension Room
Phone: 202-347-3000
Fax: 202-466-9082 (Concierge)
Attire: Business
OPEN PRESS

PARTICIPANTS: Approx. 325 to attend.
(See briefing book for further information.)

FORMAT:
- Judy Woodruff, CNN Anchor and IMFA Board Member, makes welcoming remarks and intros HRC.

- HRC makes remarks. (Approx. 10 minutes)

- HRC takes questions from the audience.

NOTE: Judy Woodruff will moderate the question and answer period.

- Following last question, Kathy Bushkin and Barbara Cochran will proceed to stage to thank HRC and present her with a gift.

-HRC will exit stage right and depart.

Contact: Nancy Marlow 703-820-0607
Staff Contact: Lisa Caputo 456-2960

10:05 am

DEPART Mayflower Hotel
EN ROUTE the White House
(Drive Time: Approx. 5 minutes)

10:10 am

ARRIVE The White House South Portico.

10:15 am-
10:20 am **DROP BY w** [redacted] 001
Diplomatic Reception Room
CLOSED PRESS

Contact: Carolyn Huber 456-2957

NOTE: WH Photographer will be present.

10:55 am **PROCEED TO OEOB**

11:10 am-
11:45 am **SATELLITE FEED** to American Academy of Physician Assistants (AAPA)
Room 459 OEOB
OPEN PRESS at event site (San Antonio, TX)

NOTE: The satellite is a two way audio and one way video.

PARTICIPANTS: Approx. 4,000 expected to be in a attendance.
(See briefing book for further info.)

11:10 am - Ann Elderkin, National President, AAPA, intros HRC.

11:15 am - HRC makes remarks and asks Ann Elderkin if there are any questions from the audience.

11:25 am-
11:43 am - Ann Elderkin and other Physician Assistants read questions that have been submitted from the audience.

11:44 am - Closing remarks by Ann Elderkin.

11:45 am - Screen fades to black.

Contact: Nancy Hughes 210-270-2986
Staff Contact: Lisa Caputo 456-2960

12:30 pm-
2:00 pm **SENATE SPOUSES LUNCH**
State Dining Room
CLOSED PRESS

PARTICIPANTS: Approx. 110 expected to attend. (See briefing book for further info.)

FORMAT:
- HRC and Mrs. Gore meet in the Diplomatic Reception Room and proceed to the First Ladies Garden.
- HRC and Mrs. Gore arrive in the First Ladies Garden to mingle.
- Guests are escorted to the State Dining Room.
- HRC and Mrs. Gore are announced into the State Dining Room.
- HRC makes brief remarks and intros Mrs. Gore.
- Mrs. Gore makes brief remarks and both HRC and Mrs. Gore then proceed to tables for lunch.
- Lunch is served.
- Following desert, Pianist Glen Pearson performs for 15 to 20 minutes.
- HRC returns to the stage and Mr. Peterson for his performance and all the guests for attending.
-HRC and Mrs. Gore depart.

Staff Contact: Ann Stock 456-7136

2:15 pm- 2:30 pm — **PVT MTG** w/Maggie Williams and Patti Solis
Residence

2:30 pm- 2:45 pm — **PVT MTG** w/Maggie Williams
Residence

3:00 pm- 4:00 pm — **PRIVATE MEETING**
Residence

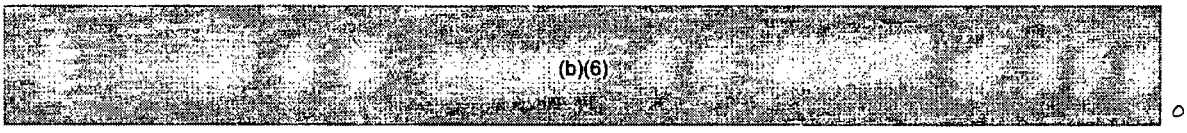
4:15 pm- 5:00 pm — **PHONE AND OFFICE TIME**

7:30 pm — **PRIVATE DINNER**
Cocktails: Yellow Oval Room or Roosevelt Terrance
Dinner: Blue Room
Attire: Business
CLOSED PRESS

PARTICIPANTS: Approx. 60 expected to be in attendance.

NOTE: The President will arrive to the dinner at 8:00 pm.

RON The White House



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WEATHER FORECAST FOR WASHINGTON, DC
--Mostly cloudy with afternoon thunderstorms. Wind south to southwest at 10 to 18 knots. Low 63 to 68. High 82 to 87.

WASHINGTON DC EVENTS:
KENNEDY:
--Sheer Madness

ARENA STAGE:
--A Room of One's Own
--The Revenger's Comedies Part I & II
--Hedda Gabler

AAPA General Session
Outline
May 25, 1994

There will be five chairs on stage for Ann Elderkin, Dr. Ernesto Gomez, Debbie Gerbert, Randy Bundschu, and Steve Crane. There will be five chairs just behind the curtains for the people asking questions to Mrs. Clinton. The five questioners will come on stage while Mrs. Clinton is speaking and then leave the stage after the satellite feed.

10 a.m. — Ann Elderkin, President, American Academy of Physician Assistants (AAPA), calls the meeting to order and asks the military PA Color Guard to present the Colors

10:10 — Elderkin explains that AAPA has been involved in numerous health care reform activities. One was to meet with the President and First Lady at the White House following the unveiling of the Health Security Act.

We are pleased today to have First Lady Hillary Rodham Clinton as our keynote speaker. (or words to that effect) (Applause)

CLINTON CUE: "Good Morning, Mrs. Clinton"

10:15 to 10:30 — Mrs. Clinton speaks. During her talk the five PAs who will be asking questions come from behind the curtain and stand near the podium.

When Mrs. Clinton finishes speaking, Elderkin thanks the First Lady and announces there are a couple of PAs who would like to ask you some questions.

Elderkin introduces each PA before they speak -- Here is a question from (NAME), a rural PA (or primary care PA, or surgical PA, etc.) from (STATE).

10:30 to 10:44 — Questions from PAs at podium and answers from Mrs. Clinton.
The PA questioners we've arranged so far:

- Rebecca Pinto, primary care PA from California
- Tom Harward, rural PA from West Virginia (was at the March White House Rose Garden ceremony with health care providers)
- Dawn Morton-Rias, Vice President of the Association of PA Programs, and Director of the SUNY at Brookland PA Program in New York
- Ron Nelson, primary care PA from Michigan

We also are trying to find a rural PA from Texas to ask one of the questions.

10:44 a.m.	Elderkin thanks Mrs. Clinton for speaking to the conference attendees.. It has been an enlightening discussion for the PAs who are attending this conference and, I hope, an educational experience for you, Mrs. Clinton. (Or words to that effect)
10:45	Elderkin gives a quick report on the AAPA donation of $5,000 to El Centro del Barrio (which operates several clinics in San Antonio for low-income and homeless people), introduces Ernesto Gomez, PhD, CEO of El Centro, and presents him with an oversized, mock check.
10:50 to 10:55	Dr. Gomez speaks (Applause)
10:55	Elderkin introduces Debbi Gerbert, Incoming President of AAPA
10:57 to 11:07	Gerbert speaks
11:07	Gerbert introduces Randy Bundschu, Speaker of the AAPA House of Delegates
11:10	Bundschu speaks
11:20	Bundschu gives the Podium back to Elderkin
11:21	Elderkin introduces Steve Crane, Executive Vice President of AAPA
11:22	Crane speaks -- will use the video tape of the CNN story on Cal Belton, a rural PA in southern California
11:29	Elderkin closes out program PROMPTLY at 11:30 a.m.

American Academy of Physician Assistants

950 North Washington Street
Alexandria, Virginia 22314

703-836-2272
FAX-703-684-1924

March 22, 1993

To: Barbara Woolley

From: Nicole Gara

Subj: Description of AAPA

The American Academy of Physician Assistants is the national organization representing the nation's 22,000 practicing physician assistants (PAs) and 3600 students enrolled in the country's 55 accredited PA programs. The association, founded in 1968, has a national headquarters in Alexandria, Virginia, and chapters in all 50 states, the District of Columbia, Guam, the Air Force, Navy/Coast Guard, Army, Public Health Service and Veterans Administration.

The Academy educates the general public about the PA profession, assures competency of physician assistants through active involvement in the accreditation of PA programs and the certification of physician assistants, provides continuing medical education programs, and conducts PA-related research. The Academy also represents the profession to the government.

The mission of the Academy is to promote quality, cost-effective and accessible health care and to promote the professional and personal development of physician assistants.

National Health

(1) The American Academy of Physician Assistants is dedicated to providing quality, cost-effective health care to all in need. At present, such health care is not equally accessible to all Americans. The AAPA believes that the U.S. health care system has become so flawed that drastic overhaul is necessary.

Problems Beset Systems: Decreased Access, Increased Costs

(2) The U.S. health care system has achieved a very high quality of care in the world, but this quality of care has never been accessible to all citizens. Access to care is often limited by factors of geography and insufficient personal funds to pay for services. People in remote areas have less access to the rudimentary services than people in populous areas. Individuals and families who cannot pay for services are forced to seek charity care or do without.

(3) During the 1930s and 1940s, access was improved for some segments of society as health care insurance gained prevalence in the workplace as an employee benefit. The federal government entered the health care delivery field in the 1940s by subsidizing biomedical research and hospital construction, thereby facilitating access to acute care across the country. In the 1960s, the federal government also began to pay for the health care services of the elderly and the indigent, through Medicare and Medicaid, and started to subsidize the education of health care practitioners.

(4) Although the infusion of private and public funds improved access for covered groups, other groups had to resort to charity or denial if their personal resources could not meet their needs. Escalating health care costs, fueled largely by corporate and government funding, exacerbated their plight. Both private and government insurance programs reimbursed providers on the basis of costs incurred, creating a powerful incentive for inflation. In an effort to offset higher costs of care, private insurers began to practice market segmentation and experience-rated premiums. As a result, high risk groups became subject to higher premiums and reduced access to care. Although federal programs expanded coverage in the 1970s, many people remained unprotected by either private or public insurance. Federal cost cutting in the 1980s also reduced sources of funding that health care institutions could draw upon to subsidize charity care.

(5) The exact number of uninsured Americans, although unknown, has been estimated at nearly 32 million.[1] The number of underinsured is estimated as high as 20 million.[2] The uninsured comprise many of society's most vulnerable population groups, including the poor and children. Many workers in small firms, as well as minimum wage and part-time employees and the self-employed, make up significant portions of the uninsured and underinsured. In many cases, the absence of adequate insurance has caused sick people to avoid necessary care or to avail themselves of inappropriate services. Physician assistants have all too often found themselves treating patients whose health status has deteriorated because they have delayed care for financial or lack of coverage reasons. Many providers, including PAs, report that the coverage status of patients often determines the course of medical treatment available to them. The existence of medically underserved populations such as the poor, minorities, pregnant women, and the geographically isolated serves as an indictment of the current structure of the U.S. health care system.

(6) Health care inflation has risen more rapidly than the economy has grown, threatening to devalue the levels of coverage provided by government and private insurance plans. National health care expenditures rose from $75 billion in 1970 to $600 billion in 1987.[3] Federal outlays related to health equaled nearly $145 billion in 1987, rising more than 700% from 1970 figures. Health care costs will continue to rise in the future. One authority projects that national health care expenditures will be $1 trillion in 1995 and $1.5 trillion in the year 2000.[4]

(7) The causes of health care inflation are complex and interrelated. Contributing forces are fiscal, social, and economic policies of state and federal governments, consumer demands and demographics, and established preferences for the organization and financing of health care. Specific influences include:

- a general inflation, which increases the costs of labor and facilities;
- the average advancing age of the U.S. public;
- the ability under the current system for health care providers to set fees and stimulate demand for services;

- o increasing development and use of costly medical technology;
- o unnecessary and inappropriate use of medical services and facilities by both providers and consumers;
- o escalating costs of administering health care services;
- o expanding malpractice litigation, resulting in higher malpractice insurance premiums and defensive medicine;
- o third-party payer assumption of payments for health care services, removing the patient's incentive to moderate his or her use of services; and
- o lack of rational distribution or coordination of health care services.

(8) Many methods have attempted to control costs under the current system. Examples include fee schedules, prospective payment, capitation and managed care. Cost control efforts by payers have had only limited success and have resulted in transferring costs to other forms of care or other providers. Another undesirable side effect has been the creation of costly insurer and provider bureaucracies, which increasingly take patient care decisions out of the hands of patients and providers. The total cost of health care administration in the United States in 1983 amounted to $77 billion, or 22% of all spending for health care.[6] United States insurance companies absorb 12% of premiums for overhead; Canadian operating companies take 3%. U.S. hospitals devote 18% of hospital spending to administration and billing, while Canadian hospitals devote 8%.[7]

(9) Patient care is often dictated by the kind of coverage available rather than the most appropriate treatment regimen. In addition, providers often are subject to retroactive denial of claims and slow payment. They also must devote substantial resources to administrative measures to ensure compliance with insurance requirements. These systemic problems have hindered the ability of providers to treat patients.

Consumers Desire Change

(10) The U.S. public appears contented with the quality of its health care services but apprehensive about the adequacy of coverage provided by private and public sources. In 1990, 93% of Americans reported that they considered their health care to be of good quality, and only 6% considered their care to be inadequate.[8] In another poll taken the same year, however, Americans reported less satisfaction with the health care system than did the residents of 10 other nations, although per capita spending exceeded that of the other countries.[9] According to the same poll, 89% of Americans desire a fundamental change in the health care system.

(11) The public's concern with the status quo stems from its fear about the adequacy of its health insurance coverage. Those with either employer or government insurance coverage fear that these programs will cover fewer expenses in the future and that they, the beneficiaries, will need to pay more out-of-pocket expenses. These fears are well founded. The household share of health services and supplies rose from a low point of 38% in 1980 to 42% in 1987, as both employers and government attempted to minimize increases in their health care costs.[7] The uninsured, on the other hand, have no assistance in paying medical bills and consequently often postpone care. Thirty-eight percent of the public in 1987 reported that the cost of medical care often inhibits visits to the physician or the purchase of medication, up 11% from 1981.[5] If people with insufficient coverage are unlucky enough to face a catastrophic illness, they may face financial ruin.

(12) Although Americans are unhappy about their health care system, no consensus for reform has emerged. On one hand, the public's support for a government-financed national health plan has reached a post-World War II high (67% of persons surveyed).[8] On the other hand, only 34% would pay more than $100 extra in annual taxes to fund such a program.[10] Similarly, Americans favor expansion of covered health care benefits but oppose higher health care costs and other disincentives for utilization of services.[11] Although Americans are opposed to paying higher income taxes for expanded health care services, they would support taxation of employers or cigarettes and alcohol for this purpose.[11]

Solutions Lack Consensus

(13) The public's uneasiness about the adequacy of its health care system has spawned a number of proposed solutions, but lack of consensus has contributed to political paralysis in this regard. Options tend to fall into three categories: incremental reforms, universal expansion of the current system, or creation of a single-payer system. (For a detailed description of current reform proposals, see the

Government Affairs section of the March 1991 issue of the Journal.)

(14) Those who advocate incremental reforms favor continuing the policies of the past decade while expanding benefits. Government and private health care insurers would each control outlays by adjusting reimbursement approaches and controlling utilization. The advocates of this strategy may also favor such antagonistic concepts as competitive, free-market, or regulatory alternatives, but they are uniformly skeptical that a comprehensive solution will control costs and believe that such an approach is harmful to the U.S. economy. Although recent incremental reforms, such as inpatient Medicare outlays, have restrained some health care costs, the growth of overall health care inflation, coupled with inadequate provision of health care services, stands as a criticism of this approach.

(15) The second grouping of reform initiatives would expand the current system of health insurance to provide coverage for everyone. Employers would be required to cover all employees and unemployed dependents. Small businesses would be helped to meet requirements by measures such as tax credits or risk pools. Unemployed persons would be covered by expansion of the federal Medicare and Medicaid programs. Advocates of this approach tout its political feasibility because none of the interested parties — consumers, providers, or insurers — would be asked to sacrifice their basic interests by acceding to such a scheme. Advocates are diverse and include the Pepper Commission, the American Medical Association, and Sen. Edward Kennedy (D-MA) and Rep. Henry Waxman (D-CA). The proposals are directed more toward providing universal coverage than controlling utilization or preventing cost-shifting. They would do little to curtail the costly health care bureaucracy or temper the wasteful duplication of technology that is a feature of the current system.

(16) The third option is radical restructuring to create a single-payer system. The practice of cost-shifting would be ended by creating either a central financing authority or a government-dominated network of payers that would be able to discipline the health insurance system. Partisans look favorably on the Canadian system, which provides universal and comprehensive care at less cost per person than does the U.S. system. Canada's federal and provincial governments determine

provider reimbursement levels, and administrative costs are low compared with those of the country's southern neighbor. Canadian health care providers and consumers appear to favor less-intensive forms of health care services, with fewer tests and physician and hospital visits, than do their U.S. counterparts.[12] In 1987, Canada spent 8.3% of its national income on health care and the United States spent 11.1%. Despite this disparity in spending, the relative health status of the citizens of both countries has been comparable.

(17) One example of a single-payer system was recently proposed by the American College of Physicians, which called for a national program of universal access funded by tax revenues. Another proposal, by Rep. Pete Stark (D-CA), would extend coverage under Medicare to all Americans and would be financed by a surtax on individual incomes over $16,000 and by corporate incomes.

(18) The single-payer proposals purport to expand coverage and control costs by inhibiting cost-shifting. Citing the Canadian example, proponents argue that the cost of expanded coverage can be offset by the savings inherent in a single-payer system and by the apparent reduced demand for health care services. Quality and access to care should improve under such a system. Proponents of a single-payer system believe cost containment will result from reductions in bureaucratic and administrative costs. Critics are skeptical, arguing that bureaucratic intrusion will increase as the system becomes more politicized and that a profit-minded provider community will be able to manipulate even a single-payer system in the absence of explicit utilization controls. They contend that the Canadian experience is not relevant to the culturally diverse and consumer-oriented U.S. society.

The AAPA Takes a Position

(19) The AAPA represents 19,000 PAs in clinical practice who provide medical treatment for 150 million patient visits per year.[13] The mission of the AAPA is to promote quality, cost-effective, and accessible health care and to promote the professional and personal development of PAs.

(20) The AAPA views its role and that of its members as one of advocacy for excellence in patient care. The AAPA believes that it has an obligation to address the deficiencies in the U.S. health care system and, where possible, to advance

proposals to correct these deficiencies. In a spirit of inquiry and cooperation, the AAPA seeks a dialogue on the issue of a national health care program.

(21) The following principles are advocated as guidelines for the development of a national health care program.

Mission

(22) The mission of a national health care program is to ensure access to quality, cost-effective health care for all residents of the United States. Health care is defined as activities or services intended to heal injuries, minimize suffering, and prevent or cure disease.

Services

(23) A national health care program should provide basic health care services to all residents. These services should include all mainstream medical, dental and mental health services.

(24) The scope of basic health care services provided under a national health care program should be determined by public policy, influenced by qualified health care professionals and consumers, and based on considerations of medical effectiveness, technology assessment, bioethics, and resources (human, financial, and research).

(25) A national health care program should assure that health care services conform to acceptable standards of care.

Structure

(26) Health care services should be provided by qualified persons who practice a team approach to care. Patients should retain a choice of providers, have access to a variety of health services, and should be satisfied with the quality of care offered by the providers and the health care system.

Providers

(27) The structure of a national health care program, including eligibility and reimbursement criteria, should be determined by the federal government. State governments may administer the program under national guidelines. Financing mechanisms should assure adequate funding, be fair, equitable, and include cost controls. One such mechanism is a combination of progressive income tax and corporate taxes, designated for health care.

(28) The AAPA advocates a national health care program based on these principles because the existing fragmented system inhibits access and is inherently inflationary. Only a well-managed national health program can guarantee universal access and moderate health care expenditures. Cost controls in this program should focus on prevention of inappropriate cost-shifting, elimination of excess bureaucracy, and use of reimbursement mechanisms that reduce unnecessary utilization of services without inhibiting beneficiary access to necessary services. Efforts should also be made to reform the malpractice system in a way that will benefit both providers and patients. Research to eliminate costly, ineffective medical procedures should continue. Although these steps will realize substantial savings, additional revenues likely will be needed to provide universal access.

(29) The AAPA believes that a national health care program should enhance the relationship between the patient and the health care practitioner. The patient, and when appropriate, the patient's family, should be the ultimate decision makers in matters of treatment after receiving competent medical advice. Health care practitioners have an obligation to educate their patients regarding how to promote health, prevent disease, and select from among treatment options. Working together under the protection of a national health care program, patients and practitioners can make rational, informed decisions that collectively will improve the nation's health status while moderating national health care costs.

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12. Grumbach K. "National health insurance in America—can we practice with it? can we continue to practice without it?" West J Med 1989;151:210-16.

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FAX Transmission

To: Barbara Woolley

White House Task Force on Health Care Reform

Fax Number: 202 456 6218

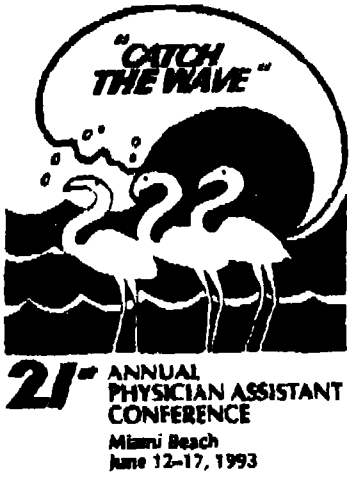
From: Nicole Gara

Day and time sent: 3/22/93 ~~4:45~~ pm 5 pm

Number of pages (including cover sheet): 7

If you are missing pages, please call (703) 836-2272, ext. 3202

Comments:



American Academy of Physician Assistants

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Date + Time change

April 25, 1994

SM

Fill May 25

Ms. Patti Solis
Special Assistant to the President
Director of Scheduling for the First Lady
The White House
Washington, DC 20500

Dear Ms. Solis:

Last month, you informed me that the First Lady more than likely will be unable to attend the 22nd Annual Physician Assistant Conference in San Antonio, Texas. We have had a slight change in our conference schedule, and I am writing to invite Mrs. Clinton to speak to the attendees by satellite.

new date 5/25

Our Saturday, May 21, conference schedule includes a two-hour review and discussion on health care reform. It is scheduled to run from 8 to 10 a.m. Central Time (9 to 11 a.m. Eastern). We would welcome comments from the First Lady at any time during this time period.

I hope Mrs. Clinton will be able to join us electronically. If you have any questions about this request, please contact Nancy Hughes, Public Affairs Administrator, at ext. 3505. Thank you for your assistance.

Sincerely,

Stephen C. Crane, PhD, MPH
Executive Vice President

Must be last day

American Academy of Physician Assistants

950 North Washington Street
Alexandria, Virginia 22314

703·836-2272
FAX·703·684-1924

May

Patti —
We need to
do a satellite
if we
can get

February 18, 1994

First Lady Hillary Rodham Clinton
White House
Washington, DC 20500

Attn: Patty Solis
Director of Scheduling

SM

Dear Mrs. Clinton:

The more than 27,000 physician assistants in the United States would be honored to have you as their guest speaker at the 22nd Annual Physician Assistant Conference at the Convention Center in San Antonio, Texas, this coming May.

AAPA applauds the work you have done to bring public attention to our health care crisis. We would welcome what words of encouragement and enlightenment you may have to help us in the national effort to make universal health care coverage a reality.

We have set aside time on Wednesday, May 25, from 10 to 11:30 a.m. for a general session for all PAs. I hope your schedule would permit you to speak on that day. We anticipate that 4,000 PAs will be in attendance at the conference. You would be speaking at the one major plenary session for the conference. Please direct any questions about the conference to Debbi Marquardt at 703-836-2272 ext. 3403.

I look forward to hearing from your office.

Sincerely,

Stephen C. Crane, PhD, MPH
Executive Vice President

call to
set up

Dear Ms Vaveer:
Lisa Caputo suggested I share this letter with you. AAPA sincerely hopes Mrs. Clinton will be able to attend. Please call me if you have any questions about this invitation —
Nancy Hughes

American
Academy
of Physician
Assistants

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MEMORANDUM

to: Patty Solis, Director of Scheduling, Office of the First Lady
from: Steve Crane, Executive Vice President, AAPA
date: May 17, 1994

Thank you again for scheduling Mrs. Clinton to address the 22nd Annual Conference of Physician Assistants.

To help her and her staff prepare for the May 25th event, I have enclosed the following information about the physician assistant (PA) profession:

Information booklet, "PArtners in Medicine"
Background sheet on the Health Security Act and PAs
Recent article about physician assistants that appeared in the Journal of the American Medical Association
Two articles about PAs
An article about the differences between PAs and nurse practitioners
An article about PAs in New Jersey, the latest state to pass legislation to allow PAs to practice (after many years of fighting legislative roadblocks set up by the state medical society and the state nursing association)
An article explaining why PAs want physician supervision, but nurse practitioners don't (a major difference between the two professions)

There are a couple of points that Mrs. Clinton may want to keep in mind when addressing the group:

- Of the more than 23,000 clinically practicing PAs, approximately 50% work in the primary care specialties -- family medicine, internal medicine, pediatrics, emergency medicine.

- Over 40% of all practicing PAs are women, even though when the profession was started in the late 1960s the first PAs were former military medics, who were men.

- According to the Department of Health and Human Services, the geographic distribution of PAs more closely matches the general population than other primary care providers. The House Budget Committee's bill report for the FY95 Budget Resolution states that "physicians assistants are the primary health care and emergency services deliverers for a high percentage of rural Americans."

- In all cases, PAs practice medicine with the supervision of licensed physicians. Most state laws allow a PA to treat patients when the physician is away from the practice and allow a PA to staff remote and rural clinics with physician located in another town.

(more)

I also though it might be helpful to address a couple of issues of professional sensitivity:

- First, the correct legal title of the profession is physician assistant -- not physician's assistant or physicians' assistant. A physician's assistant could be any individual who provides assistance to a doctor, including front office staff.

- Second, there are numerous differences between the PA and nurse practitioner education programs, certification procedures, and their scopes of practice. A major difference is in the importance PAs place on the team approach to health care by practicing with physician supervision. Talking about the two professions collectively -- as "mid-level providers" or "physician extenders" -- insinuates no philosophical or professional differences between the two. Many PAs don't work like nurses and many NPs don't work like PAs.

- Third, PAs have been compared to family nurse practitioners (FNPs) because the two professions are educated to handle patients from birth to death. It is incorrect to compare PAs to clinical nurse specialists, geriatric or pediatric nurse practitioners, nurse midwives, or in general to "advanced practice nurses" because these nurse specialists have received an education limited to specific age groups or diseases.

The program on May 25th is scheduled to go as follows:

10 a.m. Central Time -- Ann Elderkin, National President, AAPA, will call the General Session to order and discuss what AAPA has been doing in Washington, DC, and throughout the country concerning health care reform. She also will mention the visits she has made to the White House (for two Rose Garden ceremonies) and the meetings PAs and AAPA staff have had with the Health Care Task Force members and White House staff. Judith Feder was a guest speaker at a national AAPA leadership conference in Alexandria, VA, last fall.

10:10 a.m. -- Elderkin will explain the satellite feed, how the Q&A session will work and introduce Mrs. Clinton

10:15 a.m. -- (God and modern technology willing) Mrs. Clinton will address the 3,000 or so PAs attending the conference

10:30 a.m. or so -- Mrs. Clinton will conclude her remarks and ask Ann Elderkin if there are any questions from the audience

10:35 to 10:45 a.m. -- Elderkin and other PAs will read questions that have been submitted by the physician assistants attending the conference

(more)

10:45 a.m. -- Elderkin will thank Mrs. Clinton for taking the time to address the PAs and the satellite will go dark. We are considering reserving 45 minutes on the satellite (in case there are problems at the beginning or end of the transmission), so the Q&A may run a few minutes after 10:45, if that's OK.

10:50 a.m. -- Elderkin will introduce Ernesto Gomez, CEO of El Centro del Barrio, a series of health care clinics for low-income and homeless people. AAPA is presenting to Gomez a check for $5,000 to help underwrite Centro's immunization program which has served tens of thousands of low-income San Antonio children since 1980.

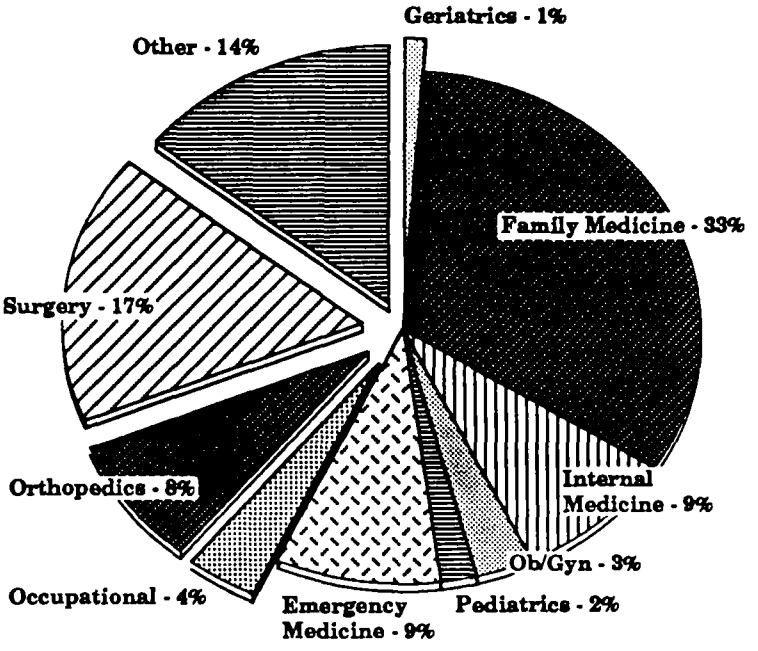
11 a.m. -- Reports from various PA leaders

11:30 a.m. -- General Session adjourns

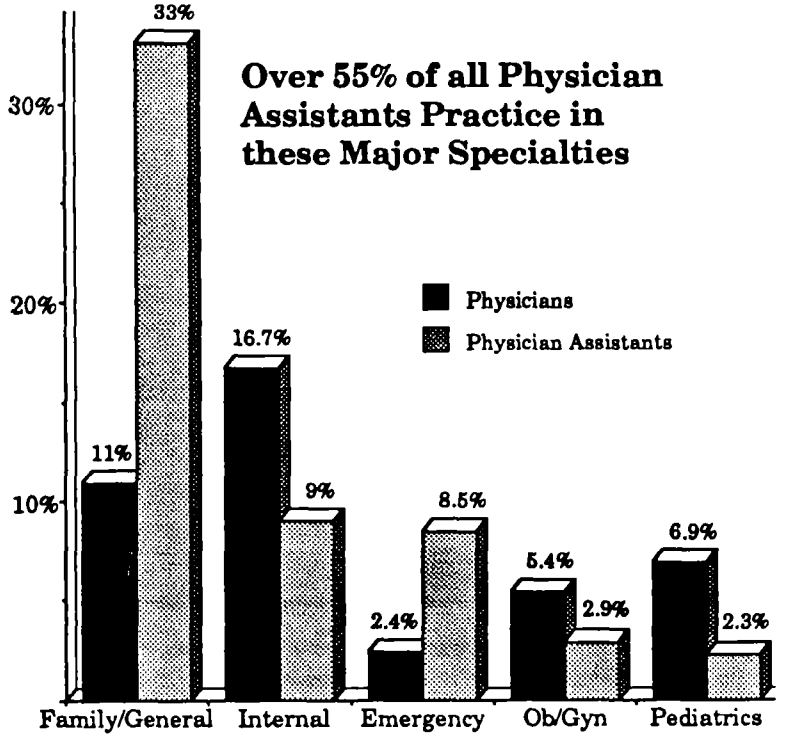
If you should have any questions concerning the arrangements for Mrs. Clinton's presentation or about the AAPA Conference in general, please call me or Nancy Hughes, AAPA Public Affairs Administrator, at the Marriott Rivercenter -- 210-223-1000 -- or at the AAPA Convention staff office -- 210-270-2973/2972.

Physician Assistants: PArtners in Medicine

- Physician Assistants (PAs) practice medicine with the supervision of licensed physicians.
- Of the 27,000 PAs who have been trained, approximately 23,500 are currently in clinical practice (87%).
- PAs are educated in a medical program and are qualified to treat approximately 80% of the patients seen by primary care physicians.
- PAs can write prescriptions in 37 states and the District of Columbia.
- Seventeen percent (17%) of all PAs practice in rural communities with fewer than 10,000 people; 34% in towns with fewer than 50,000 people.
- Seventy percent (70%) of all PAs practice in outpatient settings (clinics, HMOs, medical offices).
- PA distribution more closely matches the population than other primary care providers.
- There are 58 specially designed PA training programs located at medical colleges and universities, teaching hospitals and through the Armed Forces. The programs are accredited by the American Medical Association's Committee on Allied Health Education and Accreditation.
- A typical PA student has a bachelor's degree and over 4 years of health care experience prior to admission.



Over 50% of all Physician Assistants Provide Primary Care Services



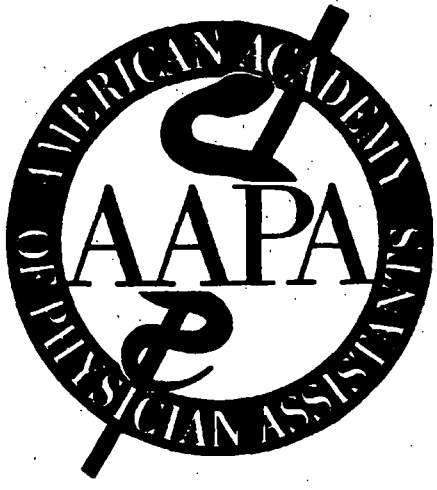
Source: Physician Characteristics and Distribution in the U.S., 1993, American Medical Association, and 1993 Census, American Academy of Physician Assistants (AAPA). AAPA includes emergency medicine when discussing primary care because of the large number of people relying on hospital emergency rooms for basic services.

- PA education is typically 24 months in length representing approximately two-thirds that of medical students (102 compared to 153 weeks).
- Nearly all states require PAs to pass a national certifying examination administered by the National Commission on Certification of Physician Assistants (NCCPA).
- To maintain certification, all PAs must complete 100 hours of continuing medical education every two years, and take a recertification exam every six years, the only major health profession with such a requirement.
- According to the Congressional Office of Technology Assessment, "within the limits of their expertise, PAs provide care that is equivalent in quality to the care provided by physicians."
- Studies conducted by the RAND Corporation have found that PAs save as much as 20% of the costs of medical care, can perform 80% of the routine functions of a physician's practice, and are widely accepted by patients.
- Case law reveals that PAs have been involved in very few malpractice suits.
- Current national statistics indicate approximately six (6) jobs for every new PA graduate. The Department of Labor projects the number of PA jobs will grow by 44% from 1990 through 2005.

American Academy of Physician Assistants
950 N. Washington St., Alexandria, VA 22314
(703) 836-2272

AAPA

Physician Assistants:



PArtners in Medicine

Official Definition of
Physician Assistant

approved by the
American Academy of Physician Assistants (AAPA)
House of Delegates
May 1991

"Physician assistants (PAs) practice medicine with supervision by licensed physicians. As members of the health care team, PAs provide a broad range of medical services that would otherwise be provided by physicians.

It is the obligation of each team of Physician/PA to ensure that the physician assistant's scope of practice is identified; that delegation of medical tasks is appropriate to the physician assistant's level of competence; that the relationship of, and access to, the supervising physician is defined; and that a process of performance evaluation is established. Adequate and responsible supervision of the PA contributes to both high quality patient care and continued professional growth.

The AAPA is committed to the concept of physician assistant practice of medicine with supervision by licensed physicians."

HOD 1303-01-01
7-26-93

PHYSICIAN ASSISTANTS

BACKGROUND

Physician assistants (PAs) practice medicine with supervision of licensed physicians, providing patient care services that would otherwise be performed by physicians.

Overview

The relationship between a physician and a physician assistant (PA) is one of mutual trust and reliance. The PA's responsibilities depend on the type of practice, his or her experience, the working relationship with the physician and other health care providers, and state laws.

Educated in a medical program, PAs are qualified to perform approximately 80 percent of the duties most commonly done by primary care physicians. PAs perform physical examinations, diagnose and treat illnesses, order and interpret lab tests, suture wounds, set fractures, and preform minor surgery. In a majority of states, PAs write prescriptions.

PAs Practice Medicine

Physician assistants follow a medical model of patient care and practice medicine with supervision by licensed physicians. PAs perform a wide range of medical duties, from basic primary care to high-technology specialty procedures. Specific duties are defined by state regulation and practice setting, but include both diagnostic and therapeutic procedures. PA education also prepares physician assistants to deal with many medical emergencies. PAs often act as first or second assistants in major surgery, and provide pre- and post-operative care.

In some rural areas, where physicians are in short supply, PAs serve as the only providers of health care, conferring with their supervising physicians and other medical professionals as needed and as required by law.

Education

PAs are educated in one of 58 specially designed PA programs located at medical colleges and universities, teaching hospitals, and through the Armed Forces. Due to the close working relationship PAs have with physicians, PA education was designed to complement that of physicians.

PA programs generally require applicants to have at least two years of college education and previous experience in health care. The typical PA student in 1992 had a bachelor's degree and over 4 years of health care experience prior to admission to the PA program. PA education is usually 24 months in length and is approximately two-thirds that of medical students (102 weeks compared to 152). PAs take some of the same classes with medical students.

The first phase of PA education is in the classroom, providing students with an in-depth understanding of medical sciences. Additional subjects include differential diagnosis, medical ethics, and pharmacology. The second year is spent in clinical rotations. Each year, PA programs graduate approximately 1,700 men and women. The majority of all PA programs offer a baccalaureate degree upon completion; twelve have master's degree programs or master's options.

Practice Credentials

Nearly all states require PAs to pass a national certifying examination before they can begin practicing. The exam, open only to graduates of accredited PA programs, is given each year by the National Commission on Certification of Physician Assistants (NCCPA), an independent organization established to assure the competency of PAs.

To maintain certification, PAs must complete 100 hours of continuing medical education every two years and take a recertification exam every six years. Only those with current certification can use the credentials Physician Assistant-Certified or "PA-C."

Practice Settings

Today there are over 27,000 PAs in the United States; over 40% of all practicing PAs are women. PAs practice in almost all health care settings and every medical and surgical specialty. They also serve on the White House medical staff.

Seventeen percent of all PAs practice in rural communities with fewer than 10,000 people; a third practice in towns with fewer than 50,000 people. The majority of all PAs (57%) practice primary care, with 33% in family medicine. Seventeen percent practice in surgical specialties. Approximately 70% of all PAs practice in outpatient settings (clinics, HMOs, medical offices), and 30% practice in inpatient settings (hospitals).

Growth of the PA Profession

Demand for PA services is rapidly increasing. Current national statistics show there are approximately six jobs for every new PA graduate. The Department of Labor projects the number of physician assistant jobs will grow by 44% percent from 1990 through the year 2005.

Factors that have contributed to this growth include Medicare/Medicaid reimbursement for PA services and increased recognition of the quality of care that PAs provide.

• • • •

"Conceived during the new health practitioner movement of the 1960s, physician assistants have demonstrated their clinical effectiveness both in terms of quality of care and patient acceptance."

— Eighth Report to the President and Congress on the Status of Health Personnel in the United States

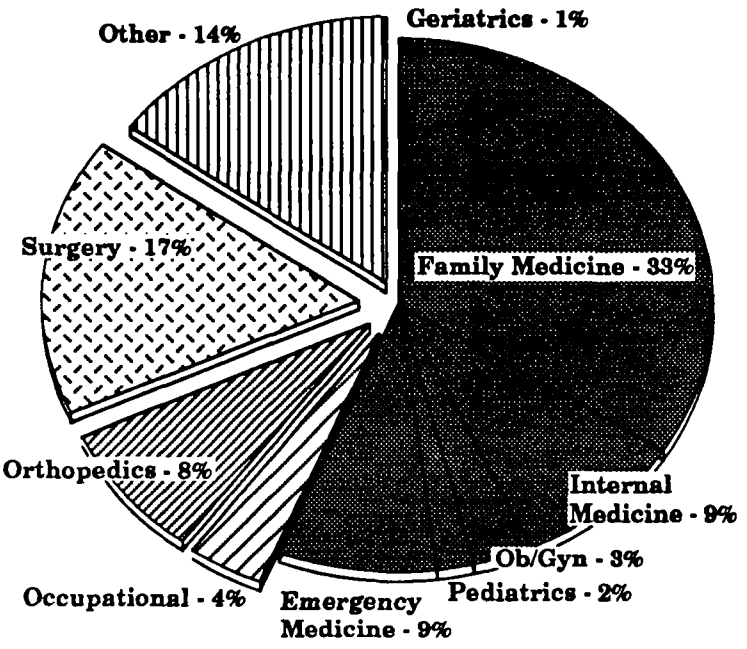
Practice Settings

Physician assistants (PAs) practice medicine with the supervision of licensed physicians, providing patients with services ranging from primary medicine to very specialized surgical care.

Currently there are over 27,000 physician assistants in the United States, nearly double the number just ten years ago. In some rural areas, where physicians are in short supply, PAs serve as the only providers of health care, conferring with their supervising physicians as needed or required by law.

While most physician assistants are in primary care settings such as a family practice, PAs also are filling roles that were not anticipated when the profession began. Some of these practice settings include nursing homes, HMOs, and occupational medicine. Many hospitals, faced with a shortage of physician residents, have discovered the value of physician assistants. PAs even serve on the White House medical staff. Physician assistants practice in nearly all medical and surgical specialties.

The PA profession has demonstrated its ability to adapt to a constantly changing health care environment. Having become an integral part of health care delivery, it is likely that PAs will continue to find, and fill, new and expanding roles in health care.



Most Physician Assistants Practice Primary Care Medicine

In 1993, 17 percent of all physician assistants worked in rural communities with fewer than 10,000 residents. Twenty percent practiced in cities with more than a million people. Fifty-seven percent of all PAs practice primary care, which AAPA defines as including family medicine, internal medicine, pediatrics, geriatrics, obstetrics and gynecology, and emergency medicine.

The PA profession is one of the fastest growing fields in health care. The Department of Labor predicts a 44% increase in the number of PA positions from 1990 through the year 2005. Nationally, the demand for PAs exceeds the supply of new graduates by 6 to 1. Since its inception over 25 years ago, the physician assistant profession has grown in size, stature, and importance. Today PAs are fully integrated into the health care system and are highly valued medical professionals.

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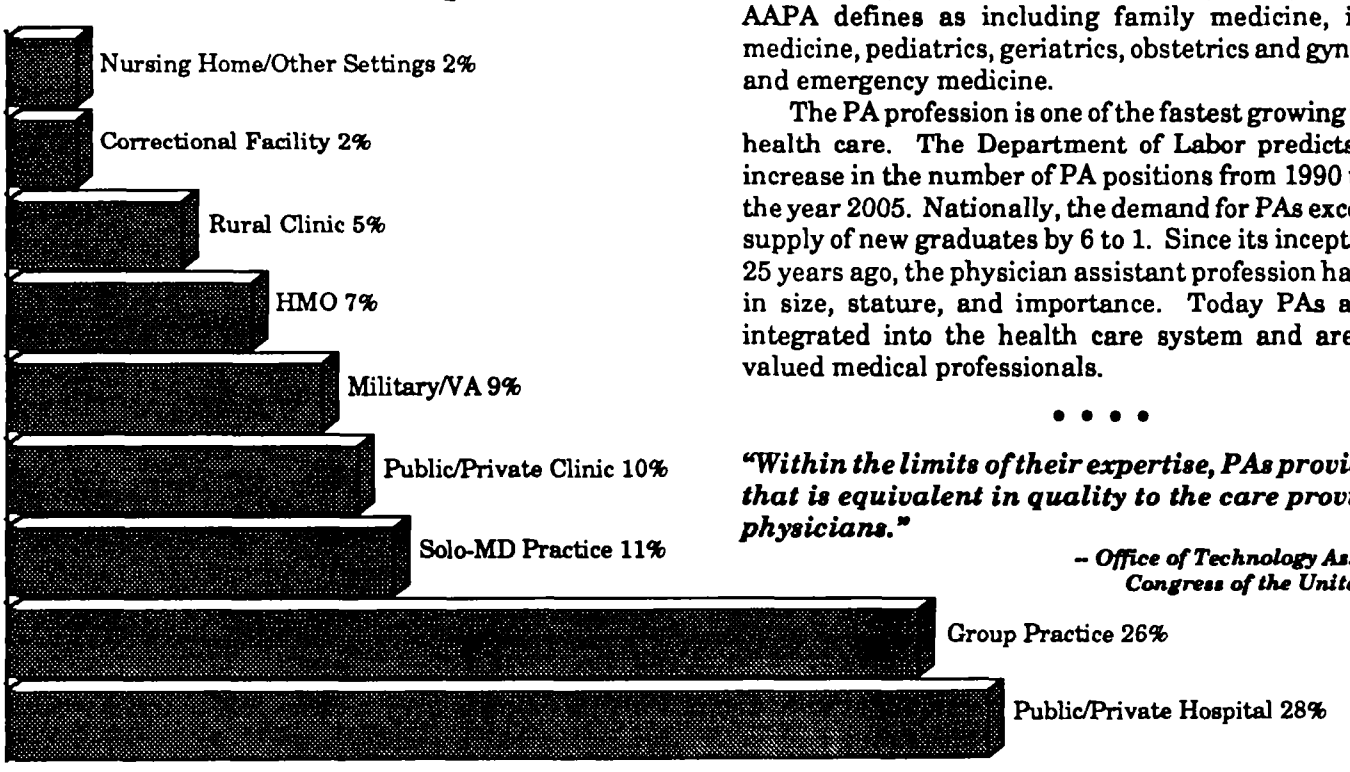
"Within the limits of their expertise, PAs provide care that is equivalent in quality to the care provided by physicians."

– Office of Technology Assessment
Congress of the United States

Approx. 70% work in outpatient settings (clinics, HMOs, medical offices) and 30% in hospitals



PHYSICIAN ASSISTANTS

EDUCATION

PA education was modeled after physician's training -- including continuing medical education to keep abreast of medical advances.

Overview

Physician assistants are trained in an intensive medical education program that usually lasts 24 months in length. The program is offered at medical schools, colleges and universities, teaching hospitals, and through the Armed Forces. Because of the close working relationship between physician assistants and physicians, PA education was modeled after physician's training and is similar in structure, albeit shorter than medical school. Physician assistants often attend the same classes with medical students.

The first year is composed of classroom instruction, with a heavy emphasis on medical sciences and related disciplines. Second-year PA students perform clinical rotations, seeing and treating patients. Some programs offer specialty training.

The Students

The typical PA student in 1992 had a bachelor's degree and over 4 years of health care experience prior to admission to a PA program. Fifteen percent of all physician assistants were nurses, 14% were emergency medical technicians, 13% were medics, and 9% were emergency room technicians before they became PAs. There is fierce competition to get into a PA program. In 1992, PA programs turned away five qualified applicants for every student accepted.

The Programs

There are 58 physician assistant programs in the United States, graduating approximately 1,700 PAs a year. Programs are accredited by the American Medical Association's Committee on Allied Health Education and Accreditation (CAHEA). Only graduates of accredited PA programs are eligible to take the national certifying examination.

National Certification

Most states require PAs to pass the national certification examination, offered by the National Commission on Certification of Physician Assistants (NCCPA). Only those successfully completing the examination may use the credentials "Physician Assistant-Certified" or "PA-C."

A PA's education does not end at graduation. In order to remain certified, physician assistants are required to complete 100 hours of continuing medical education (CME) every two years and take a recertification examination every six years. It is the only major health profession with such a requirement.

Degrees Awarded

All PA programs offer a certificate upon graduation; most offer a bachelor's degree. Twelve of the programs also have a master's degree program or master's options. More than 70% of all physician assistants have a bachelor's degree, and an additional 12% have a master's degree or higher.

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"Since the inception of the discipline in the 1960s, physician assistants have become firmly established as a provider group well suited to address problems of maldistribution of physicians and enhancing cost-effectiveness in health care."

-- Eighth Report to the President and Congress on the Status of Health Personnel in the United States

PAs IN THE US

In 1967
The physician assistant concept originated during the mid-1960s. Physicians and educators recognized there was a shortage and uneven distribution of primary care physicians. To combat these problems, the physician assistant program was developed. The first physician assistants graduated from Duke University in 1967. They were former Navy corpsmen who wanted to use their medical skills in civilian life.

Today
A majority of all PAs provide primary care, and 33% practice in towns with fewer than 50,000 residents. PA distribution more closely matches the population than other primary care providers according to the *Seventh Report on the Status of Health Personnel in the United States*, published by the U.S. Department of Health and Human Services in 1990. The report noted that, were it not for PAs, many areas would have little or no access to quality health care.

The PA Practice
Physician assistants work in all 50 states, the District of Columbia, Guam, and around the world in the military. In 1992, there were approximately 152 million patient visits to physician assistants.

The median salary range for clinically practicing physician assistants nationwide is $50,000 to $55,000, which is approximately half the average salary of a family physician.

All PAs must, by law or regulation, have a supervising physician. It is not necessary, however, for the physician and PA always to be located in the same building or even the same town. Most state laws allow the supervising physician to be away from the practice when the PA is seeing patients.

• • • •

"(Congress has) singled out programs in family medicine, general internal medicine, and general pediatrics, and training of physician assistants. . . for priority in the allocation of federal assistance because these professions will play a pivotal role in reaching the national goal of making access to primary health care more widely available and of reducing unnecessary health care costs."

–United States Congress, 1992
Public Law 102-408

Quality Care
A study by the Congressional Office of Technology Assessment concluded that "within the limits of their expertise, PAs provide care that is equivalent in quality to the care provided by physicians." Studies conducted by the Rand Corporation and others found that PAs save as much as 20% of the costs of medical care, can perform 80 percent of the routine functions of a primary care physician's practice, and are widely accepted by patients.

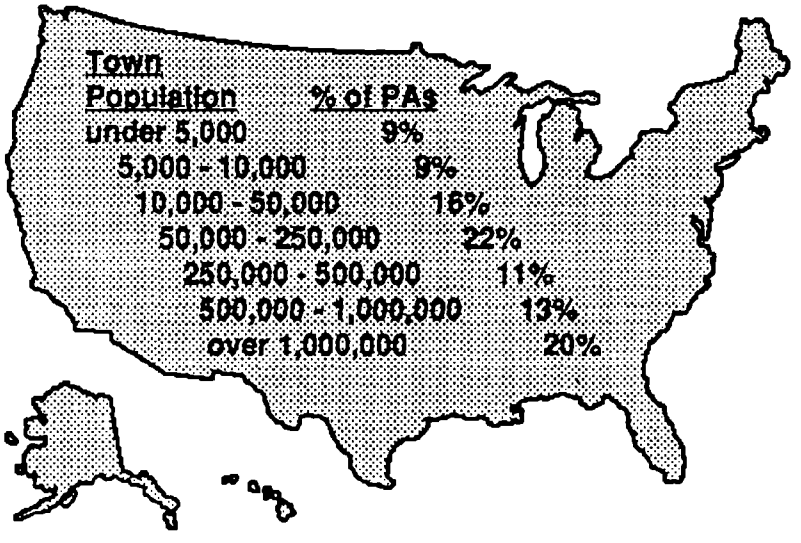
Case law reveals that physician assistants have been involved in very few malpractice cases. The majority of PAs are insured by a rider on their employer's malpractice policy; many have their own coverage.

Prescribing
A PA's practice is determined by education and experience, the supervising physician's practice, and state law. One aspect of state law is prescriptive authority.

During the last decade, the number of states granting prescriptive authority has more than doubled. Thirty-seven states, the District of Columbia, and Guam allow PAs to write prescriptions for medications.

Prescriptive practice for physician assistants is a logical outgrowth of both their role and education. PA education in pharmacotherapeutics (the study of the use of medication in the treatment of disease) is proportionally equivalent to that of physicians. The National Board of Medical Examiners determined that the PA national certification examination is a valid assessment of this knowledge. Surveys show a strong similarity between PA and physician prescribing patterns.

A state-by-state summary of the laws and regulations governing PAs is available from the American Academy of Physician Assistants.



ORGANIZATIONS

American Academy of Physician Assistants

The American Academy of Physician Assistants (AAPA) is the national professional society for PAs. Founded in 1968, the Academy has chapters in all 50 states, the District of Columbia, and Guam. There are also chapters that represent physician assistants working for the Public Health Service, the Department of Veterans Affairs, and all branches of the military.

The mission of AAPA is to "promote quality, cost effective, and accessible health care and to promote the professional and personal development of PAs." Major activities to accomplish this goal include government relations, public education, research and data collection, and professional development.

Eighty percent of all practicing physician assistants are members of AAPA. Members are graduates of accredited physician assistant programs and/or those who are nationally certified. Students at accredited programs are also eligible for membership.

The AAPA's Physician Assistants Foundation (PAF) provides funds for scholarships and research on the PA profession. In 1992, it awarded 37 scholarships totalling $87,000 to PA students and $15,000 in research grants to AAPA members.

For more information, contact:
American Academy of Physician Assistants
950 North Washington Street
Alexandria, VA 22314
(703) 836-2272

National Commission on Certification of Physician Assistants

The National Commission on Certification of Physician Assistants (NCCPA) is an independent organization established to assure the competency of physician assistants. The NCCPA was formed in 1975 by AAPA and other health professional associations in order to administer a national certifying examination to graduates of accredited PA programs. The examination and the recertification exam physician assistants are required to take every six years are designed to test the medical knowledge and clinical skills of PAs.

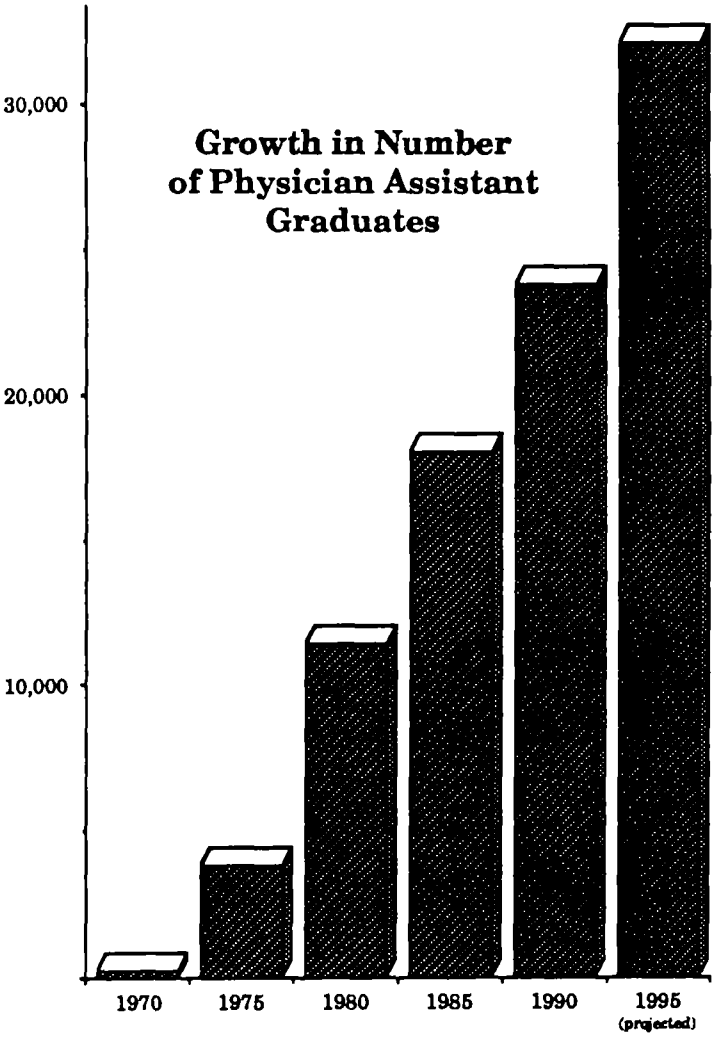
For more information, contact:
NCCPA
2845 Henderson Mill Road NE
Atlanta, GA 30341
(404) 493-9100.

Association of Physician Assistant Programs

The Association of Physician Assistant Programs (APAP) shares its national headquarters with AAPA. Whereas the Academy is made up of graduates and students, APAP members are the physician assistant educational programs and faculty. Founded in 1972 to help maintain the high quality of PA education, APAP's objectives are to encourage communication among the programs and to serve as a national information center on PA education.

APAP publishes the "National Directory of PA Programs," giving complete information on the names, locations, requirements, tuition, length, and degree(s) awarded for each of the accredited PA programs. The directory is available to the public for a small fee.

For more information, contact:
Association of Physician Assistant Programs
950 North Washington Street
Alexandria, VA 22314
(703) 548-5538



NATIONAL HEALTH CARE REFORM

President Clinton's health reform legislation, the "Health Security Act" (HR 3600, S 1757), seeks to provide quality health care to all Americans, including millions of individuals who are currently uninsured or underinsured. To accomplish this goal, the bill recognizes physician assistants (PAs) as qualified health care professionals who provide essential, cost-effective health care.

▲ Health care teams

By defining "health professional services" to include physicians and others legally authorized to provide services, the legislation recognizes that physician assistants provide quality health care that should be available to all Americans under health care reform. PAs are included in the definition of "lawful health care provider" whose services must be covered under any fee-for-service plan offered by a regional alliance.

PAs are specifically listed in the definition of health professionals who may be considered "essential community providers" eligible for certification. Health plans would be required to contract with institutions, agencies and providers certified as essential community providers in order to assure that underserved populations have access to care.

▲ Increased funding for PA education

Authorized spending has been set at $400 million to cover "primary care physician and physician assistant training," plus programs for the training of underrepresented minorities and nurses. The American Academy of Physician Assistants (AAPA) seeks specific earmarking of funds for PA educational programs.

The legislation changes the financing of graduate medical education. Rather than coming entirely from the Medicare trust fund, physician residency training would also be supported by money set aside from private health insurance premiums collected by corporate and regional alliances. In a precedent-setting move, the bill allots $200 million of these funds for graduate nurse education. The AAPA believes that PA education programs should also be eligible for GME funds, which is a steady source of financial support immune from discretionary spending caps and the annual appropriations process.

▲ Enhancement of PA practice environment

The legislation recognizes that physician assistants are essential to the delivery of primary care and preventive services, particularly if all Americans are to have access to quality health care. It includes language encouraging and supporting full utilization of the "professional education and clinical skills of advanced practice nurses and physician assistants."

Within the Department of Health and Human Services, programs are authorized to encourage the adoption of model professional practice statutes for PAs and to support the removal of inappropriate barriers to practice. The AAPA seeks the addition of language directing the Secretary of HHS to consult with the appropriate professional society on the issue of a model law.

The Health Security Act does not provide for a federal preemption of restrictive state practice acts. Rather, it declares that "No state may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals." The AAPA supports the removal of unnecessary practice restrictions, but does not believe the federal government should override state laws.

▲ Increased access for Medicare beneficiaries

The legislation amends existing law and extends Medicare coverage for outpatient physician services provided by PAs from rural Health Professional Shortage Areas to all geographic areas. Reimbursement would be paid to the PA's employer at 85 percent of the physician's fee. This provision is essential and must be included in any health care reform legislation enacted by Congress.

▲ **Support for providers in underserved areas**

The bill increases funding for the National Health Service Corps ($50 million in FY95, $100 million in FY96, and $200 million for each of fiscal years 1997 to 2000). The AAPA recommends replacing the bill's proposed requirement that 20 percent of all NHSC participants be nurses with language doubling the current 10 percent set-aside of scholarship and loan repayment awards for PAs, nurse practitioners and nurse midwives.

The Health Security Act contains a $500 per month personal tax credit for primary care physician assistants practicing full-time in Health Professional Shortage Areas. The AAPA recommends modification of the recapture provisions for PAs unable to complete the 60-month mandatory service period and extension of this credit to PAs working in underserved areas prior to 1995. The AAPA recommends the extension of the tax credit beyond five years.

The AAPA also recommends that Medicare bonus payments, currently available only to physicians, be authorized for PAs working in underserved areas.

▲ **Miscellaneous provisions**

The legislation authorizes $200 million for skill enhancement and retraining programs to be administered by the Department of Labor. These include retraining health care workers for more advanced positions as technicians, nurses, and physician assistants.

The Health Security Act would establish a National Council on Graduate Medical Education, a National Council on Graduate Nurse Education, and a National Institute for Health Care Workforce Development. The AAPA recommends that Congress consider consolidation of these functions to avoid unnecessary bureaucracy and to achieve more effective workforce planning and administration.

AAPA National Health Reform Policy

The American Academy of Physician Assistants believes that a national health care program should provide basic health care services to all residents and that the scope of such services should be determined by public policy and be based on considerations such as medical effectiveness. Health care services should be provided by qualified persons who practice a team approach to care. Patients should retain a choice of providers and be satisfied with the quality of care offered by the providers and the health care system.

In addition, AAPA believes that the structure of a national health care program should be determined by the federal government, and administered by the states under national guidelines. Financing mechanisms should be fair, equitable, and include cost controls.

The AAPA advocates a national health care program based on these principles because the existing fragmented system inhibits access and is inherently inflationary. Only a well-managed national health care program can guarantee universal access and moderate health care expenditures.

AAPA Position on the "Health Security Act"

Therefore, to the degree that the President's "Health Security Act" meets these principles, the American Academy of Physician Assistants can support the proposal. The AAPA applauds the bill's focus on universal access and comprehensive primary and preventive care services; its emphasis on a team approach to health care delivery; its attention to research on effective medical procedures; and its preservation of the patient's right to choose his or her health care provider.

5/94

Special Communication

Physician Assistants and Health System Reform

Clinical Capabilities, Practice Activities, and Potential Roles

P. Eugene Jones, PhD, PA-C, James F. Cawley, MPH, PA-C

NATIONAL efforts to reform the health care system will likely result in changes in the roles and responsibilities, practice combinations, and distribution of health professionals, including midlevel providers such as physician assistants (PAs), nurse practitioners (NPs), and certified nurse-midwives. Although recent studies have addressed differing scenarios of the projected roles of midlevel providers,[1-6] implementation of initiatives that involve PAs may be influenced by an overall shortage of PAs, existing barriers to PA practice, and the need for commitment to physician-dependent practice relationships in a team-oriented health care delivery system. This article reviews the history, academic preparation, clinical capabilities, distribution, and practice activities of PAs and discusses the potential roles of PAs in the changing health system environment.

The origin of the PA can be traced to the new health practitioner movement of the 1960s, during which the PA concept emerged from a combination of events. As experienced hospital corpsmen and combat medics returned from service in Vietnam, there were no civilian job equivalents or suitable health career pathways in the United States. Simultaneously, a new health care provider model proposed in 1961[6] resulted in the development of the first PA program at Duke University School of Medicine. According to this concept, PAs "would be trained to assist the doctor . . . in such a way as to facilitate better utilization of available physicians and nurses."[7] These circumstances eventually resulted in the matriculation of substantial numbers of military veterans into newly developing PA programs. Subsequently, more PA programs were developed to train providers who would (1) augment the capabilities of primary care physicians by increasing access to basic medical care services, (2) fill service gaps resulting from geographic and specialty maldistribution of physicians, and (3) help control health care costs.[8,9]

From the Physician Assistant Program, Department of Health Care Sciences, University of Texas Southwestern Medical Center at Dallas (Dr Jones), and the Physician Assistant Program, Department of Health Care Sciences, The George Washington University, Washington, DC (Mr Cawley).

Reprint requests to University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235-9090 (Dr Jones).

PA EDUCATION

By 1993, there were 58 accredited PA programs in 29 states and the District of Columbia and 27 403 program graduates.[10,11] With the exception of a few hospital-, military-, and community college–based programs, the majority of PA programs are affiliated with academic health centers (AHCs), medical schools, or 4-year colleges and universities, 26% of which are classified as category I research universities by the Carnegie Foundation for the Advancement of Teaching.[12] Thirty-five PA programs (60%) offer a baccalaureate degree or degree option, 12 (21%) offer master's degrees, and the remainder grant an associate degree or a certificate of completion.

Essentials for PA Education

The "Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician" were initially adopted in 1971 by the American Medical Association in collaboration with the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Society of Internal Medicine.[13] Following the organization of the Committee on Allied Health Education and Accreditation in 1977, the Essentials were revised in 1978, 1985, and 1990. The Essentials establish minimum standards of quality to which accredited programs are held accountable. After the Essentials initially were adopted, federal funding acts supported the expansion of PA educational programs' emphasis on a primary care orientation for preparing generalist PAs.[14]

According to the current Essentials of the Committee on Allied Health Education and Accreditation, PAs are "academically and clinically prepared to provide health care services with the direction and responsible supervision of a doctor of medicine or osteopathy. The functions of the physician assistant include performing diagnostic, therapeutic, preventive and health maintenance services in any setting in which the physician renders care, in order to allow more effective and focused application of the physician's particular knowledge and skills."[15(p6)]

Clinical services performed by PAs are described by the Essentials in the following six categories[15(pp6-7)]: (1) *evaluation*—initially approaching a patient of any age group in any setting to elicit a detailed and accurate history, perform an appropriate physical examination, delineate problems, and record and present the data; (2) *monitoring*—assisting the physician in conducting rounds in acute and long-term inpatient care settings, developing and implementing patient management plans, recording progress notes, and assisting in the provision of continuity of care in office-based and other ambulatory care settings; (3) *diagnostics*—performing and/or interpreting, at least to the point of recognizing deviations from the norm, common laboratory, radiological, cardiographic, and other routine diagnostic procedures used to identify pathophysiological processes; (4) *therapeutics*—performing routine procedures such as injections, immunizations, suturing and wound care, management of simple conditions produced by infection or trauma, and assistance in the management of more complex illness and injury, which may include assisting surgeons in the conduct of operations and taking initiative in performing evaluation and therapeutic procedures in response to life-threatening situations; (5) *counseling*—instruction

and counseling of patients regarding compliance with prescribed therapeutic regimens, normal growth and development, family planning, emotional problems of daily living, and health maintenance; and (6) *referral*—facilitating the referral of patients to community health and social service agencies when appropriate.

Curriculum Content

Prior to matriculation, the typical PA program requires the student to have completed the equivalent of 2 years of undergraduate-level biological, social, and behavioral science prerequisites. The first 9 to 12 months of PA education are devoted to preclinical didactic studies and include courses in anatomy, physiology, microbiology, pharmacology, psychology, clinical medicine, physical diagnosis, preventive medicine, and clinical laboratory procedures.[16] Courses in the basic medical sciences account for 77% of the didactic component of PA education, with the remainder devoted to behavioral and social sciences. Educational programs for PAs average more than 1004 contact hours of didactic instruction.[17] These courses are typically followed by 9 to 15 months of physician-supervised clinical education in both inpatient and outpatient settings in urban, inner-city, and rural communities.

In some AHCs, didactic PA education and medical student education is conducted with shared classes and resources, and PA students typically are educated in a clinical setting by residents, attending physicians, and graduate PAs. Most programs include supervised clinical educational experiences for PA students in rural or medically underserved areas. In addition, several hospital- and university-based postgraduate courses of instruction exist in medical and surgical specialties such as neonatology, pediatrics, emergency medicine, occupational medicine, and surgery.

Primary Care Deployment Models

A number of PA programs have developed specialized curricula designed to promote primary care practice in underserved communities, including content on substance abuse education for health professionals, geriatrics, mental health, health care for the homeless, women's health initiatives, environmental/occupational medicine, medical Spanish, and a general orientation toward prevention in the delivery of health care.[14] Many programs have successfully placed graduates in chronically underserved areas via decentralized educational projects.[18,19] For example, participants in the Stanford University Primary Care Associate Program were twice as likely to be employed in rural communities (<10 000 population) as nonparticipants (33% vs 16%).[20] A 1992 survey of participants in the University of Nebraska PA Program's Rural Health Opportunities Project revealed a similar graduate employment rate (33.4%) in communities with fewer than 10 000 population.[21] More recently, a satellite educational project developed by the University of Washington–MEDEX Northwest Physician Assistant Program provides on-site didactic and clinical education for rural and Native Alaskan matriculants in Sitka, Alaska, and additional MEDEX Northwest projects link the University of Nevada and Boise State University with area health education centers for rural PA deployment.

Several PA programs have developed master's degree majors for PAs who will serve underserved populations and areas of special need. Graduate PA programs in rural health are offered at Alderson-Broaddus College in Philippi, WVa, and the University of Nebraska–Omaha. Public health education is offered in combined PA/MPH programs at The George Washington University, Washington, DC, and the University of Oklahoma in Oklahoma City, and a combined PA/MS degree in preventive medicine is offered at the University of Iowa in Iowa City.

AHC-Affiliated PA Programs

Of the 58 accredited primary care PA programs, 27 (47%) are sponsored by AHCs. Twice as many AHC-based PA programs receive federal grant support as non–AHC-based programs, and at a 12% greater dollar amount than non–AHC-based PA programs. Because federal PA training grants are tied to demonstrated success in primary care education and graduate placement in health professional shortage areas, it follows that AHC-sponsored PA students spend more time in primary care–based clinical education and are employed in primary care settings at a greater rate than non–AHC-sponsored students.[22] Consequently, AHC-based PA programs may be better positioned than non–AHC-based programs to contribute to the goals of the Health of the Public Program[23] by providing interdisciplinary didactic and clinical education in population-based competencies, by continuing emphasis on health promotion and disease prevention activities,[24] and through PA faculty service and student rotations that augment community access to health care services.

Funding Sources

In 1993, 33 PA programs received a total of $6.65 million in federal training support under Title VII authorization through the Health Resources and Services Administration Grants Program for Physician Assistants of the Public Health Service, administered by the Division of Medicine. In the same year, the mean PA program budget was $457 000 and the average Title VII grant award was $143 000, which accounted for 28% of program operating costs.[22] Fiscal year 1995 authorization is $9 million.

Title VII funding preferences and priorities for PA program education grants have traditionally emphasized primary care education and deployment, affiliation with graduate programs in family medicine, and strategies for increased enrollment and retention of underrepresented minorities. Funding preferences and priorities for the fiscal year 1994 application cycle address medically underserved community practice, generalist specialty practice, and increased enrollment of minorities or low-income applicants.

From the inception of PA educational programs, internal support from sponsoring institutions has increased steadily while external (primarily federal) support has remained at about one third of total program revenues. This trend reflects increasing self-sufficiency on the part of PA programs, because the level of federal support during the past 7 years has remained relatively constant.

The overall cost of PA education remains relatively low. The average total cost for educating a PA student is approximately $8029 per year at AHC-sponsored programs and $7546 per year at non–AHC-sponsored programs.[22]

Response to Federal Initiatives

Educational programs for PAs have responded to federal grant initiatives by specifically targeting curriculum content toward primary care for medically needy populations. This includes special focus on topics such as the acquired immunodeficiency syndrome, substance abuse, adolescent pregnancy, childhood immunizations, risks of cancer and heart disease, and reduction of infant mortality. More than half of all PA programs have developed specific educational content to address the health and medical problems of inner-city populations. Most PA programs have developed strong linkages with area health education centers, community education centers, rural health clinics, community/migrant health centers, and other primary health care agencies and settings. Fellowships for PAs in migrant health centers are jointly sponsored by the Health Resources and Service Administration, National Rural Health Association, American Academy of Physician Assistants, and Association of Physician Assistant

Table 1.—Physician Assistant Specialty Distribution, by Percentage, 1974 Through 1993*

Specialty	1974 N=939	1978 N=3416	1981 N=4312	1984 N=6552	1987 N=10 682	1993 N=14 746
Family practice	43.6	52.0	49.1	42.5	38.7	34.5
General internal medicine	20.0	12.0	8.9	9.2	9.5	9.5
General pediatrics	6.2	3.3	3.4	4.1	4.0	2.3
General surgery	12.1	5.5	4.6	5.1	8.8	6.4
Surgical specialties	6.8	6.2	7.7	12.5	13.8	20.6
Medical specialties	3.9	6.3	2.7	4.8	7.1	6.0
Emergency medicine	1.3	4.9	4.5	6.4	6.5	8.2
Occupational medicine	1.8	2.7	3.1	4.1	4.1	3.1
Other†	4.3	7.1	16.0	11.3	7.5	9.4

*Sources of data are references 10 and 29.
†Other includes pediatric specialties, physical and rehabilitation medicine, psychiatry, public health, and radiology (all <1%); 3.3% were not identified.

Programs to promote PA practice in migrant health settings.

Faculty

Educational programs for PAs experience difficulty in identifying, recruiting, educating, and retaining sufficient numbers of qualified faculty members. The combination of an enlarging applicant pool, pressure to increase the number of PAs trained per program, and an increasing number of clinical employment opportunities has resulted in an "academic hourglass" effect, further complicated by an already insufficient supply of experienced PA educators. Because of the disparity between academic and clinical income potential, faculty positions designed as joint teaching–practicing clinician positions are commonplace means of income supplementation. Sixty-nine percent of PA faculty are concurrently engaged in part-time clinical practice, averaging 10 hours per week, earning an average wage of $26.29 per hour.[25]

As with most professional schools, no formal pathway exists for PA-specific educator training. Clinically experienced PAs are typically self-referred or recruited into PA education, usually with little or no formal preparation in the foundations of educational theory and practice.[26] Of the PA program personnel identified as faculty in 1993, 13.6% held doctorate degrees, 35.2% held master's degrees, and 49.2% held bachelor's degrees. The remaining 2% held associate degrees (1%) or were not reported.[22]

Applicants and Students

As with other health professions, interest in PA education continues to increase. In 1988, PA programs averaged 86.1 applicants for 25.9 seats. By 1992, the number of applications increased to an average of 203 per PA program (an increase of 136%), and the number of enrolled students increased to 35 per program.[22] Preliminary reports of the 1994 applicant pool indicate that many programs have nearly twice the number of applicants compared with 1993.

The typical student entering PA training is a 26-year-old white woman with a 3.1 grade point average and more than 4 years of previous health care experience. Since 1984, women have constituted more than 60% of enrolled PA students, and since 1987, ethnic minorities have represented about 20% of matriculants. Most students enter PA education with either a baccalaureate degree or substantial course work in the premedical sciences. An increasing number of matriculants (7.2% in 1993) hold master's or doctoral degrees.[25]

CLINICAL SERVICES AND SETTINGS

At present, approximately 23 350 PAs are employed in clinical practice in 49 states and the District of Columbia. Trends in practice patterns of recent PA program graduates reveal increased numbers in inpatient and institutionally based settings and, until recently, fewer entering primary care practice. In 1993, 44% of PAs were employed in primary care settings, defined as family or general practice, general internal medicine, or general pediatrics (Table 1). The largest share, 34.5%, worked in family or general practice.[10] The 28% of PAs employed by hospitals included more than 6% in outpatient clinic practice (Table 2).

The distribution of PA practice settings is geographically disproportionate. Fewer recent graduates of PA programs in eastern states entered primary care practice settings (54.4%) compared with graduates in central (73.8%) and western states (70%). Seventeen percent of PAs practice in communities with a population of fewer than 10 000, and 34% practice in communities with a population of fewer than 50 000. More than 86% of all graduate PAs remain in full-time clinical practice.[10]

Changing Profiles

The demographic profile of PAs has changed markedly since the profession's inception. Although it remains a relatively young profession (the mean age of PAs is 40 years), the proportion of women PAs is now more than 42%, increasing from less than 10% in the 1970s. Almost 10% of PAs are ethnic minorities, and more than 32% are military veterans.[10]

Nearly 35% of all PAs are employed in private physicians' practices (either solo or group) and 28.5% practice in hospitals, with other PAs distributed in health care settings such as managed care organizations (7.3%), the military (4.6%), rural clinics (4.7%), Department of Veterans Affairs facilities (4.2%), and correctional facilities (2.5%). The remainder practice in nursing homes, inner-city clinics, and other clinical settings. Notable employment trends reveal fewer PAs in family medicine and more PAs in medical and surgical subspecialties (Table 1). The proportion of PAs employed in hospital settings reflects a relatively stable distribution over the past decade (Table 2).[27]

While PA practice settings continue to diversify, the largest percentage remain employed in primary care. A number of the same socioeconomic factors that discourage physicians from practicing primary care may influence PA employment decisions as well.[8] Despite the fact that most PAs are in primary care practice, it is clear that specialty and institutional employers are competing for PA services, and the patterns of diversification and specialization of PA employment further complicate an imbalanced educational supply and occupational demand mismatch.[28]

Income

As demand for PA services has grown, salaries in both primary care and specialty settings have increased accordingly. In 1993, the mean annual salary for PAs in all practice settings and specialties was $53 500, excluding fringe benefits and part-time income. Those employed in surgical specialties earned an average of $60 800 per year.[29] In a 1991 study of 6228 PAs, with the exception of those in practice less than 1 year, salaries among men were approximately $5000 greater than among women, even after controlling for clinical specialty, number of years in practice, number of patient visits per week, and number of hours worked per week.[30]

PA Productivity and Cost-effectiveness

The potential roles to be assumed by PAs in health system reform will likely correlate with their productivity and cost-effectiveness. Outcomes will differ from practice to practice, depending on variables such as the specialty, setting, and barriers to employment. The productivity and cost-effectiveness of PAs have been described and measured by the time spent per visit, average num-

Table 2.—Trends in Physician Assistant Practice Settings, by Percentage, 1981 Through 1993*

Practice Setting	1981 N=4312	1984 N=6552	1987 N=3309	1993 N=14746
Private office†	35.8	34.5	33.2	34.6
Hospital	29.5	31.3	28.6	28.5
Ambulatory clinic‡	24.9	17.7	17.0	20.4
Health maintenance organization	NA§	NA	6.9	7.3
Military	9.4	7.3	7.6	4.6
Other‖	0.4	9.2	6.7	4.6

*Sources of data are references 10 and 29. Data for 1987 are from reference 29 only.
†Either solo or group practice.
‡Includes community-based public, privately sponsored, inner-city, substance abuse, student health, correctional medicine, and rural health clinics.
§NA indicates not available.
‖Other includes Veterans Affairs (4.2%) and nursing homes (0.4%).

ber of visits per unit of time, number of office visits or procedures, charges generated, overhead reduction, and increased physician activity.[4,31-34] In 1993, outpatient-based PAs saw an average of 22.1 patients per day, compared with an average of 15.7 patients per day for inpatient-based PAs.[10] Although many variables are influenced by the actual practice setting, the evidence suggests that physicians can increase their practices' output by employing PAs, and PAs "are capable of carrying substantial proportions of the workloads of primary-care physicians."[4(p43)]

Quality of Care

Indicators of the quality of care provided by PAs have been measured by comparing processes and outcomes between physician- and PA-provided care with regard to functions performed by both. Within their areas of competence, PAs have been shown to provide care indistinguishable in quality from care provided by physicians.[4,35] Indirect indicators of quality, such as physician acceptance and patient satisfaction, have also been favorable.[36,37] However, existing quality-of-care studies of midlevel providers have recently been criticized for being dated and methodologically flawed.[38] The need for current data derived by rigorous health services research methods is clearly indicated.

Responsibility and Accountability

State legislation governing PA scope of practice exempts PAs from the unlicensed practice of medicine with the stipulation that they function under the supervision of a licensed physician. Legally, the physician-PA relationship is one of *respondeat superior*, wherein the physician is liable for exercising care in the selection and supervision of the PA, has the right of control of the assistant, and is "liable for the negligent acts of employees performed within the scope of the employment relationship."[39(p102)] Although the supervising physician retains "vicarious liability," PA practice accountability has progressed from a delegatory model achieved by amending medical practice acts to a regulatory/authority model, wherein state licensing boards are authorized to govern PA practice. These amendments and exemptions establish PAs as the agents of their supervising physicians, and PAs maintain direct liability for the services they render to patients. Supervising physicians, who define the standard to which PA services are held, are vicariously liable for services performed by their PAs under the doctrine of *respondeat superior*.

COMPARING PAs AND NURSE PRACTITIONERS

A recent study estimated there are 27226 NPs, distinguished from other registered nurses by state boards of nursing data. Exact numbers are unknown because of overlapping NP titles, specialty practice roles, and differing state requirements for NP education and accreditation.[40] The majority of NP practice settings were reported in family and adult medicine, pediatrics, and women's health.

A 1993 study of 51 midlevel provider educational programs (22 NP, 20 PA, two combined PA/NP, and seven certified nurse-midwife programs) compared legal, professional, and political differences between PAs and NPs.[19] Although varying degrees of differences and similarities were reported between PA and NP educational programs, the main distinction in their orientation to health care is that NP programs are typically set within schools of nursing, with education provided in the nursing model. In contrast, PA programs are typically affiliated with medical schools, with education provided primarily by physicians. However, these differences are less distinct in some regards; physicians contribute to NP education, and NP and PA educators often "cross-teach" between and among programs. In California, two programs jointly train PAs and NPs within the same department, and approximately one third of California PAs are also nurses.[41]

Although PA and NP clinical roles within managed care organizations and ambulatory settings are often regarded as interchangeable, reports comparing PA and NP productivity have differed in their findings. One study reported that both groups saw similar numbers of ambulatory adult patients in a large managed care setting,[42] whereas another reported that PAs had more direct patient encounters and generated twice the gross dollar income per day when compared with NPs.[43] These differences were not fully accounted for but were partially attributed to the tendency for NPs to spend more time providing counseling services. Debate continues on the practice productivity advantages and disadvantages between PAs and NPs, but researchers appear to agree that the potential for increased productivity for both groups is greater in larger practices and managed care settings. Nevertheless, both PAs and NPs directly reflect physician levels of task delegation in their clinical productivity.[4]

The practice of PAs is regulated under states' Medical Practice Act provisions and is based on physician supervision and task delegation, whereas NPs practice under nursing licensure provisions of Nurse Practice Acts. Research evidence clearly shows that the tasks described and roles performed by PAs and NPs are more similar than different in many ambulatory practice settings, but two major issues serve to differentiate the professions: (1) their general orientation to health care and (2) the desire for independent (NPs) vs dependent (PAs) practice relationships with physicians.[44] This divergence may have important implications for both professions if health reform measures include greater roles for PAs and NPs in private practices, managed care systems, and institutional settings.

POTENTIAL ROLES OF PAs

Under federal aegis, increasing attention is now focused on a generalist-provider–oriented system of health care. However, the projected roles of PAs in such a system are still undetermined. According to the US Public Health Service, PAs "have become firmly established as a provider group well suited to address problems of maldistribution of physicians and enhancing cost-effectiveness of care," and increasing demand for PA services was attributed to the revitalization of the National Health Service Corps, liberalization of authority to prescribe, and the increased use of PAs in hospital-based settings as a means of cost-control.[45(p7)] What remains to be seen is the level of demand and the clinical practice settings in which PA services will be required.

The federal government reinforces the

primary care focus of PA program curricula by awarding Title VII training grants for programs demonstrating a record of successfully meeting primary care–oriented funding preferences and priorities. However, the possible redistribution of medical and surgical subspecialty residency educational positions recently recommended to Congress by the Physician Payment Review Commission (PPRC) and the Council on Graduate Medical Education may result in increased use of PAs and other midlevel providers in inpatient specialty settings. This may occur as a result of a PPRC-projected loss of 11 000 residency slots.[46] Among the PPRC recommendations was a call for increased funding for specialty-trained PAs and other midlevel providers to maintain levels of inpatient care previously provided by residents. Another report reinforced this proposal, suggesting a need to determine "the extent to which nurse practitioners and physician assistants can substitute for and enhance both generalists and specialists. . . ."[42(p1073)]

The PA profession realizes increasing opportunities in medical and surgical specialty practice, and the 77% of PA programs that are federally funded are obligated to maintain generalist-based curricula. Although many newly graduated entry-level PAs are initially employed in specialty settings, the more plausible solution to the potential demand for more specialty-trained PAs may be to increase the number of postgraduate and master's level specialty programs. The projected number of PAs who will graduate in 1994 is 2100. If Title VII educational grants increase as projected, approximately 3300 PAs would graduate in 1996, followed by 3800 graduates in 1997. The annual PA graduation rate would increase to approximately 4000 by the year 2000, resulting in a total of approximately 41 000 PAs in practice. This number includes the assumption of a 1% to 3% attrition rate and the remaining years of expected practice, given the mean PA age of 40 years.[47] However, the distribution of PA practice settings will likely be influenced by a combination of market forces and reform initiatives.

Hospital-Based PAs

As the proportion of PAs working in primary care practices declined during the 1980s, the proportion of hospital-based PAs remained relatively stable. However, the distribution of PAs within hospital settings has changed, from fewer PAs in hospital-based outpatient clinics to more PAs in inpatient service roles. While PAs employed in the surgical subspecialties increased from 7.7% in 1981 to 21.7% in 1993, PAs employed in hospital settings ranged between 28% and 31.3% (Table 2). By 1992, 48.6% of practicing PAs indicated at least some inpatient care responsibility.[48] In many teaching hospitals, a combination of residency program retrenching, curtailed availability of international medical graduates, and cost-control measures has contributed to expanded inpatient roles for PAs. As a result, PA use in inpatient care roles in a wide variety of hospital settings has become commonplace.

A recent study of 1690 hospital-based PAs revealed that 45% held the job title of or were identified as "house officers." More than 90% had formal medical staff privileges and were credentialed under hospital bylaws. Their practice distribution included 19.4% in surgical subspecialties, 18.6% in medical specialties, 14.8% in emergency medicine, and 9.5% in general surgery.[48] Although the study was inconclusive in determining the levels of resident physician/house officer substitution performed by hospital-based PAs, the authors recognized the need for additional PA education in liability protection and risk management and additional research in levels of responsibility, outcomes, and privileging issues.

PAs and Managed Care

The increasing management by for-profit corporations and the economies of scale realized by capitated managed care organizations require careful cost-benefit considerations in provider ratio and distribution decisions. However, many variables contribute to differing levels of PA role and distribution settings within managed care organizations. Although managed care PAs assume a range of duties in a variety of clinical settings, it appears that physician attitudes toward PAs play a major role in staffing decisions; thus, midlevel provider distribution among similar settings within the same organization can differ significantly.[43]

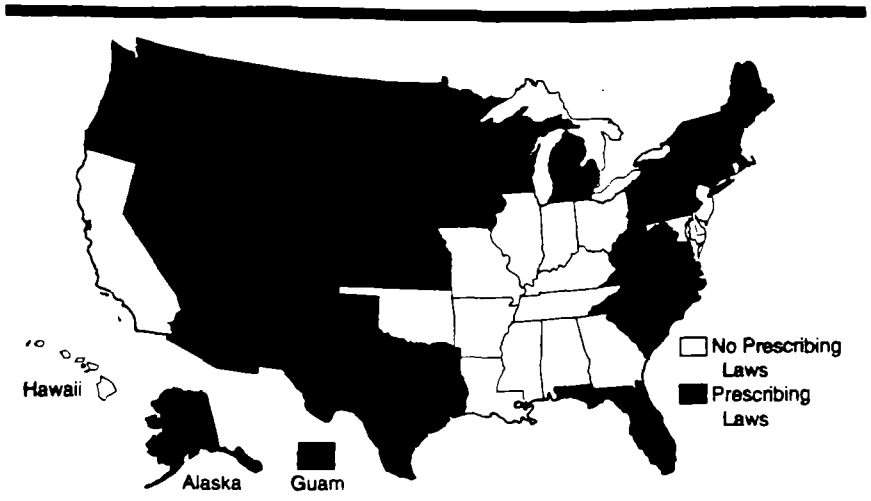
In ambulatory managed care settings, PAs have been shown to be capable of handling approximately 80% of the health care services required to manage patient problems at physician-equivalent levels of patient satisfaction and quality of care.[49] This finding is consistent with observations made in rural private practices, urban ambulatory care clinics, and geriatric settings.[19] In a large group-model health maintenance organization, physicians and PAs were found to see a similar number and type of adult ambulatory patients on an hourly, daily, and annual basis, and PAs were employed at approximately 50% of physician costs.[49] However, additional and more recent data are needed to determine frequency and appropriateness of PA consultation and referral activities, prescribing habits, rate and frequency of patient return visits, comparable degrees and mix of patient difficulty, and the amount of "nonbillable" physician time spent in consultation and supervision of PAs within such settings. In the absence of these data, the evidence indicates that, in organized ambulatory care practices where team approaches and structured division of staffing are present, PA clinical productivity compares favorably with that of physicians.[49]

BARRIERS TO PA PRACTICE

In 1993, PAs were recognized as health care providers by the medical licensing boards of 49 states and the District of Columbia; Mississippi is the only state that does not recognize PAs. State legislative and regulatory agencies maintain control over the patterns of utilization of PAs through their authority to license and regulate the profession. Barriers to enhancing the use of nonphysician health care providers were recently reported as professional territorialism, licensure restrictions, educational isolation, physician resistance, and institutional inertia.[3] These barriers vary geographically, as well as between and among differing nonphysician provider professions. As a means of reducing these barriers and encouraging change in health care delivery, the Office of the Inspector General called for an increased emphasis on supervisory and management skills in curricula for health care educational institutions and the development of cooperative practice models among different health care professions. A combination of population demographics and regulatory and reimbursement policies appears to have the greatest influence on PA practice favorability, particularly in states with disproportionate rural or medically underserved communities. However, current data that more clearly define regional and national barriers to PA practice are needed if health system reform plans include an increased use of PAs.

PA Supervision

The physician-PA employment relationship has been and is intended to remain a dependent one. The fundamental elements of PA practice (use of a referral system, frequent consultation, and periodic review) are said to be synonymous with a well-designed health system.[50] The PA's ability to consult with and refer to the supervising physician is the key factor to a successful workplace relationship, and studies suggest that the task delegation and supervision behaviors of the physician have the greatest influence on PA clinical productivity.[51] Geographic practice isolation in rural and frontier



Physician assistant prescribing authority, 1993.

settings may by necessity result in varying degrees of off-site physician supervision of the PA, and this physical separation requires a certain amount of autonomous judgment, particularly when the PA is the only available on-site provider. Regulatory reluctance to support such relationships in satellite and remote settings restricts the ability of PAs to provide needed services that might otherwise be unavailable.

Prescriptive Authority

A total of 35 states, the District of Columbia, and Guam authorize PAs to prescribe medications, but a nucleus of states do not. The cluster of 12 states (Figure) represent approximately 37% of the total US rural health professional shortage areas.[52] Although prescriptive authority varies from state to state and ranges from using protocol-based formularies for noncontrolled substances to prescribing controlled substances, PA prescribing must be done with the agreement and supervision of the physician. Patterns observed in rural PA practice in Texas reveal an example of the potential effect of prescriptive authority to increase the capabilities of PAs to improve access to care. Prior to PA prescriptive legislation passed in 1991, Texas had 26 rural health clinics. By November 1992, the number had nearly quadrupled, increasing to 99. During the same period, the percentage of Texas PAs practicing in rural areas tripled, from 5% to 15%.[53,54]

Reimbursement Issues

Variation in state laws regarding compensation for PA-provided services has also influenced PA deployment. For example, successful implementation of the Rural Health Clinic Services Act (Public Law 95-210), which provides for criteria-specific Medicare and Medicaid reimbursement for PA services, is hindered in some states by variations in the scope of their practice laws governing PAs. The practice of PAs is also complicated by state-by-state Medicaid reimbursement policies that remain inconsistent. The services of PAs are governed by the "incident to" provision, which allows for reimbursement at the physician fee level for office or clinic services provided by the physician's staff that are considered integral, although incidental, to the physician's services. The physician must be present when the PA-performed services are delivered, and the PA's services are billed and paid for as if the physician had performed them. Differing states' interpretations of the incident to physician service clause of Medicare and its carriers confuse PA employers regarding reimbursement for services provided by PAs, especially where on-site supervision is not always required, and where PAs are hired by practices for the specific purpose of extending medical services to rural and underserved communities.

Although Medicare reimburses 100% of the physician fee schedule for PA services provided incident to a physician's service, reimbursement rates for other services provided by the PA are lower. Furthermore, these rates often vary, depending on the site of the services. For example, reimbursement for PA services performed in a nursing facility may not exceed 85% of the physician rate; in a hospital setting it may not exceed 75% of the physician rate; PA-assisted surgery reimbursement may not exceed 65% of the physician rate. Medicare services rendered by PAs are always reimbursed to the PA's employer; thus, these variables must be considered when determining the most cost-effective use of PAs.

PAs AND HEALTH SYSTEM REFORM

The roles to be assumed by PAs in the forthcoming health system reform initiatives are yet to be determined. Because PA education so closely resembles a condensed version of medical school, many of the same factors that complicate physician education and distribution are similarly experienced by the PA profession.

The argument that increasing existing PA program enrollment is less expensive than developing completely new programs must be tempered with the realities of increasing institutional competition for fixed educational resources. For example, AHCs with both a medical school and a PA program may not be able to absorb the added expense, space, and time requirements of more lecture commitments by basic science faculty, resident physicians, and staff attendings; more classroom space; and more competition for already limited teaching time on ward rounds, in the clinics, and in operating rooms. Additionally, the simultaneous demand to produce more generalist physicians may increase competition among medical schools, residency programs, and PA programs for sites for quality primary care clinical education. President Clinton's Health Security Act includes favorable provisions affecting PAs, but many questions relating to the prospective roles for PAs remain unanswered. The Health Security Act does not specify how the annual $400 million allocated for primary care education among medical schools, nursing schools, and PA programs is intended to be distributed.

Although a number of proposals suggest differing roles for midlevel providers within the context of health system reform,[1,2,4,5,46,55] the fact remains that PAs are inextricably dependent on physicians for their employment and supervision. The position stated by the American Boards of Family Practice and Internal Medicine opposing independent practice by nonphysician professionals also reflects the position of the PA profession.[56] The American Academy of Physician Assistants reaffirmed that the PA profession does not seek independent practice, direct reimbursement from third-party payers, or federal preemption of state practice acts.[57] Nevertheless, if health system reform initiatives include a greater role for PAs in the provision of health care, greater efforts must be made to improve the linkages and relationships between and among PA programs, medical schools, and generalist physician residency training programs. Introducing more medical students and

residents to the roles, functions, and capabilities of the physician-PA team in educational settings might reduce the existing degree of reluctance to "work together in well-integrated teams to enhance the quality and availability of cost-effective patient care," as called for by the American Boards of Family Practice and Internal Medicine.[56(p315)]

While the PA profession acknowledges the importance of working closely with physicians, the trend of increasing specialty practice of PAs is a topic of ongoing debate between generalist and specialty PAs.[58-60] Some generalist PAs are critical of the splintering effect of professional alignment with specialty groups, whereas some specialty PAs berate their reluctance to expand with the job market. Notwithstanding the specialty vs primary care rift within the PA profession, national health system reform measures will help determine whether PAs will continue to gain acceptance and legitimacy. Although the PA profession is faced with several obstacles to growth and expanded provider roles, success or failure in a changing environment will be measured by the profession's ability to meet the needs of the medical marketplace.

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'I have more time than most physicians to spend with patients'

Name: Joan Schulhoff

Background: Schulhoff, 44, moved to Chicago 18 years ago to work for Mt. Sinai Hospital Medical Center. She has a bachelor's degree in English from the University of Cincinnati and a Physician Assistant Associate Degree from Cincinnati Technical College. Schulhoff is currently director of Federation Programs for Mt. Sinai, which runs screening and primary-care programs for Soviet Jewish refugees and community-outreach programs for the Jewish community.

Years on the job: 18

TRIBUNE PHOTO BY NANCY STONE

PHYSICIAN ASSISTANTS ARE trained at a level above nurses and below physicians. Though we do about 80 percent of what a physician can do, we must work with a physician, not independently. We do histories and physical exams. We diagnose and we treat. And we do that through a set of verbal guidelines with our physician. We work with our physician for a while, and we take on his or her style of practice.

The reason PA's and other nonphysician providers are becoming so important is that there simply are not enough primary-care physicians in this country. And it's not just in rural areas. There are many underserved people in urban areas as well.

Most of what I see in my practice are things that the physician doesn't need to be doing: pre-employment physicals, colds, strep throats, sprained ankles, stable diabetics, stable hypertensives. When something exceeds my abilities, then I talk to the physician.

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In 35 states, plus the District of Columbia and the Armed Forces, PA's can write prescriptions. In Illinois we don't yet have prescriptive privileges, but I believe that's changing. In an urban area such as Chicago it's easy to get the physician's signature on a prescription, but in rural areas, such as in Downstate Illinois, sometimes the doctor isn't around for a couple of weeks. So the PA's really need prescriptive privileges in those areas.

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Our goal is to evaluate people immediately. They often come in with undiagnosed diseases, no medication, morbid hypertension, unstable angina pectoris, cancers that have not been diagnosed, terrible lesions, grotesque medical problems. We intervene as quickly as possible. We don't just do a public health screening—we do a whole primary-care screening, and PA's do that whole initial screening. If patients need ongoing care—and many of them do—they are sent to Mt. Sinai or Michael Reese Hospital.

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One of the most touching incidents I've had was a teen-age girl who came to me for birth control. While I'm all for giving birth control to people who are sexually active, I had a sense from talking to her that she wasn't. When she came back for her exam, she was holding a stuffed doll, and I knew she was trying to tell me she wasn't ready. So we talked about it, and she agreed that she would wait six months. And she kept her part of the bargain and decided not to have sex for another year.

There are challenges, though, that I wonder if I'm going to overcome. When you have a program that loses money, you always wonder if you'll have enough glue to keep things together.

The profession, which is about 25 years old, has blossomed in the last couple of years because there's a growing awareness that there are areas where there is not enough care. And, gradually, even organized medicine has begun to realize that physicians can't do everything. The quality-of-care studies that have been done are just wonderful for PA's. Malpractice claims are almost non-existent.

To be a good PA, you have to have a strong academic background. There are no programs that will take anybody directly out of high school. The courses are very rigorous, and some are taken with medical students. You have to have good academic credentials, especially in the sciences. They also prefer people with prior health-care experience because you're thrown in with patients from the beginning. You're on a team, seeing patients with a physician, a fourth-year medical student, a resident and a PA student. You've got to be a mature person. ■

Interview by free-lance writer Norma Libman.

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First of state's physician assistants begin entering the medical system

By DONNA LEUSNER

Physician assistants are slowly beginning to practice medicine alongside New Jersey doctors after 20 years of resistance from the medical community and a year-and-a-half after Gov. Jim Florio signed a law allowing them to work in the state.

The first five licenses were approved by the state Board of Medical Examiners on July 14, although a dozen physician assistants began working in hospitals two years ago as part of a pilot project.

Working under the supervision of physicians, physician assistants can perform at least 70 percent of the clinical duties of general practitioners, allowing doctors to concentrate on more complex patient problems.

Physician assistants can record patient histories, give physical exams and injections, draw blood, take patient histories, remove sutures and administer medication.

At least 23,000 physician assistants are working around the country. In fact, New Jersey was the 49th state to pass a law allowing them to practice here; only Mississippi still prohibits their licensing.

Hospitals, operating in a new deregulated market in which competition is based on price, are anxious to have another member of the health care team, especially one who can be hired after three years of classroom and clinical training for $40,000 to $60,000—less than half the price of a general practitioner.

Beyond the walls of hospitals, physician assistants can be a valuable asset in community health facilities like the HIV clinic run by St. Michael's Medical Center in Newark or the city health department clinic.

Sister Dolores Lew divides her time between both places, learning how to examine, manage and treat patients with sexually transmitted diseases and HIV as part of her third and final year in the physician assistant program run by Rutgers University and the University of Medicine and Dentistry of New Jersey.

"There is a great need for PAs. We could alleviate 70 to 85 percent of a physician's workload and he can spend quality time with those who are more ill. We can stretch our hands to patients to help give medical care," said Lew, who spent 15 years as a medical

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Physician assistants entering medical system

Continued from Page One

technologist and blood bank specialist.

"I wanted more patient contact," said Lew, a member of the Sisters of Charity. She wants to work with the poor and treat patients physically as well as spiritually.

"I'm just sorry that some of the physicians are not open-minded to the need," she added.

For years, the state Medical Society and the state Nurses Association lobbied to keep physician assistants from practicing in New Jersey, arguing that the quality of care would suffer and that it would wind up costing the health care system more to add another layer of professionals between doctors and nurses.

"Contrary to what my friends in the Medical Society think, it improves the quality of care. Our experience here has been very positive," said Dr. Fred Jacobs, president of the state Board of Medical Examiners.

The two physician assistants who have worked in neurosurgery and orthopedics at St. Barnabas Medical Center in Livingston, where Jacobs is senior vice president for medical affairs, have worked out "extraordinarily well," he said.

Some of the hospital's medical staff members were ambivalent at first, Jacobs conceded. "Now you find doctors on our staff who were opposed to this who want to hire their own PAs," he said.

Dr. Sophie Pierog, vice president and director of the pediatrics department at Jersey City Medical Center, said she too expected problems with residents, nurses and doctors adapting to the three physician assistants working there under the pilot project.

Photo by Rich Krauss

Joseph Thornton, clinical coordinator of the physician assistant program at Robert Wood Johnson Medical School in Piscataway, watches as Sister Dolores Lew of Convent Station performs an ear examination on fellow student Linda Greer of Millstone

"But we've had smooth sailing," said Pierog, who hopes to "multiply by a dozen" the one physician-assistant she has working in pediatrics.

"Any extra help is always welcome," said Dr. Michele Reisner, the director of the emergency room at Jersey City, where she supervises a physician assistant. "I certainly would welcome more PAs in the emergency room."

Physician assistants are also working at University Hospital in Newark and Cooper Medical Center in Camden. They have worked for years in Veterans Administration hospitals and prisons in New Jersey run by the federal government.

Physician assistants who led the fight to be licensed in New Jersey and state officials who have worked on implementing the new law say the year-and-a-half delay is not unusual to get a new category of health care professional working. It takes that long, here and in other states, to develop the rules and licensing procedures for a new category of professional, they said.

"It is not easy to get a license in New Jersey," Jacobs said. "I don't apologize for that. It should not be easy. I want to make sure these people who apply are who they say they are."

The 17-member Board of Medical Examiners he heads licenses physician assistants.

"While it takes a little longer, it serves the public," Jacobs said.

Nicole Gara, director of government and professional affairs at the American Academy of Physician Assistants, said some states have taken about the same amount of time and others longer. Missouri took a year and a half. The Pennsylvania Medical Board has taken seven years to rewrite its rules after a law was passed removing authority from the board of pharmacy.

It took 18 months after New Jersey passed a law allowing respiratory therapists to practice before regulations were adopted, according to Marianne Kehoe, executive director of the physician assistant advisory committee. There are about 50 physician assistant applications in varying stages of approval, Kehoe said.

Joseph Thornton, president of the New Jersey Society of Physician Assistants and one of the first five applicants to have their licenses approved, said things are not moving as fast as he would have liked but he has seen no evidence that anyone is being "obstructionist."

Ruth Fixelle, director of the Rutgers-UMDNJ physician assistant program, said she did think the delay was "really unusually long." She said the medical board had been more "cooperative and helpful than we anticipated." Fixelle was also among the first five physician assistants granted licenses earlier this month.

New Jersey graduates have scored the highest in the country over the past few years on the national physical assistant exam, but until now they have had to look elsewhere for work. There are about 300 physician assistants living in New Jersey but working elsewhere, Thorton said.

Because they are in demand – seven jobs are waiting for every new graduate nationally – New Jersey hospitals have some recruiting to do to bring back physician assistants to the state to work, a hospital association official said.

In the meantime, physician assistants are starting a new fight. They want a bill passed (A-2806/S-1943) that would allow them to get temporary licenses between the time they graduate in May, take a national exam in October and get the results back in late January.

also ran July 7, 1993 in Allied Health Section


Judge


Nelson


Patchin

Do APNs need doctor supervision?

NP, physician and PA face off

Health-care delivery is undergoing radical surgery as lawmakers and providers grapple with the need to expand access to health care without compromising the quality of patient services.

The gap between the demand for primary care and the number of available physician providers likely will be bridged by non-physician professionals, advance-practice nurses (APNs) and physician assistants (PAs).

As APNs pursue a career agenda that will give them more autonomy, they are encountering opposition from both doctors and PAs who say physician supervision is essential.

How important is physician supervision of nurses and/or PAs to the integrity of the health-care system? Should APN primary-care specialists—nurse practitioners—be encouraged to work independently, that is, not under the direction of a physician?

We asked a nurse practitioner, a physician assistant and a doctor who worked as an RN for 15 years to comment on the emerging independent role of nurse practitioners. (Our panel's telephone-conference dialog has been edited for space.)

***Diane Judge, RN, MSN,** a certified primary-care nurse practitioner at the University Health Service at the University of Chicago, is chairperson of the Illinois Nurses Association Council of Nurse Practitioners, Chicago.*

***Ron Nelson,** a certified physician assistant at Cedar Springs Medical Center, Cedar Springs, Mich., is the former president of the American Academy of Physician Assistants.*

***Dr. Rebecca Patchin,** a fourth-year resident in anesthesiology at Loma Linda University Medical Center, Loma Linda, Calif., worked as a registered nurse in critical care and pediatrics from 1969 to 1984, before entering medical school in 1985.*

Judge: Of course nurse practitioners should work independently within their scope of practice! Supervision of nursing functions by a physician is not necessary. Collaboration with a physician, however, for practical purposes, is always necessary, unless a nurse is performing only nursing functions.

There are some areas of overlap (of nursing care and physician care), but I don't think supervision is necessary. There are many studies that show that.

Nelson: Nursing activities are best defined by the nursing profession itself. My belief—and the belief of the PA profession—is that the practice of medicine by PAs requires the supervision of a physician. And that supervision should be defined by the physician, the PA and the state's practice code.

Patchin: I think there are some (nursing functions) that may not require direct physician supervision. Incidentally, I personally prefer the terms collaboration and collaborative practice.

Above all, we must remember that each patient is a whole person and that we can't divide a human being into separate territories of nursing practice (and) medical. . . . It's sometimes difficult to define where the nurse's scope of practice and the physician's scope of practice begins and ends.

But if there are times when collaboration is indicated and necessary, then I think we've answered the question: "Should nurses work independently?" I say no.

Judge: I'm sort of uncomfortable that we're (debating) independent practice by nurses, even though nurses are out in rural areas (where physicians are scarce) and practicing independently right now—and that's okay.

Patchin: The quality of care should be the same for everyone, whether they live in a rural community, or an affluent suburban community, or an inner-city ghetto. . . . The best way to consistantly deliver quality health care is for all parties—doctors, nurses and PAs—to sit down together and agree on the scope of practice for each, which may depend upon the skills of the individual as well as the practice setting.

Nelson: One of the problems that we've experienced is what I refer to as the smoke and mirrors of collaboration and supervision . . . Hopefully, we all know what our limitations are, and that's what makes us adequate and good professionals.

We're all interested in promoting better delivery of health-care services, and that requires someone to be the head of the team. Someone has to be the captain of the ship. Obviously the physician, in terms of education and background, is the individual to provide that kind of direction and supervision.

Judge: Nurse practitioners are not proposing to do medical care. We are providing health care. Incidentally, I just have to get on record as saying I don't agree with the doctrine that the captain of the ship is the physician.

Reporter: Who is better prepared to provide primary care, a nurse practitioner who is working without direct supervision or the physician assistant who is always under a physician's supervision?

Patchin: Obviously, it's nice to have things black and white. I personally don't see that you can say who is best and who is worse. You have to look at the educational preparation and the situation.

Nelson: I really don't think education is the issue. The issue is the (provider's) qualifications to completely take care of patients. PAs are trained in the physician model; they're trained to manage patients using the same approaches that are taught to physicians.

Judge: I don't think we have to decide who's best prepared to give care. The fact is there are not enough primary-care providers.

Nelson: The bottom line is the safe practice of medicine by PAs requires a supervisory relationship. And that supervisory relationship is determined by state law, the physician and the practicing PA.

The team approach to health care is still the most effective model for delivery of health-care services. . . . PAs are part of that equation.

Judge: (Expanded) primary health-care services are basic to effective health-care reform . . . What's really important to nurse practitioners, so we can continue to provide access to that care, is professional recognition, (which includes) prescriptive authority direct reimbursement.

Patchin: I worked (as an RN) in a physician's office for a year with a family practicer and a pediatrician, and was using some on-the-job training skills at that time to do pediatric well-baby checks and female physical assessments . . . When I looked at my future life and career, I made a decision to go (to medical school), rather than to go into advance-practice nursing. That was a conscious decision. And it was based on my belief then, and my continuing belief, that the physician is the captain of the ship.

We need to ensure that our citizens have access to quality health care. I believe the best way to ensure that is through a team or collaborative approach. And to me, that does not mean having independent (APN or PA) practices.

Interviews by Mary Peterson Kauffold RN, a Chicago freelance writer.

Target Issue

'War' looms as APNs seek independence

Chicago Tribune June 30, 1993, Special Section

By Mary Peterson Kauffold, RN

Advance-practice nurses are determined to shed the last vestige of their physician handmaiden image and win the respect, autonomy and remuneration that they say still eludes them—even if it takes an act of congress in the name of health-care reform.

Both physician and nurse groups are marshalling their member forces in what may be the most volatile health-care turf battle in a long time.

At issue "is money and control," said Nancy McGinn, RN, MSN, a certified nurse practitioner who is a staff specialist in workplace advocacy for the American Nurses Association.

The ANA's position is clear: The time is long overdue to make prescriptive privileges and direct reimbursement for services legal nationwide for advance-practice nurses (APNs), who count among their ranks about 30,000 nurse practitioners, 5,000 nurse midwives, 40,000 clinical nurse specialists and 25,000 nurse anesthetists.

The ANA solution to the shortage of primary-care providers is simple: Rethink the definition of provider. "Some 60 to 80 percent of primary and preventive care traditionally done by doctors can be done by [an APN] for less money," asserts an ANA publication.

"That's where the rubber hits the road," said Dr. M. Roy Schwarz, senior vice president of medical education and science at the American Medical Association. "That's where the professions sharply divide. We'll forever be divided on that issue, because medicine believes nurses are not adequately trained to play the role of doctor."

"The quality-of-care argument just doesn't hold water," said Jan Towers, PhD, a certified nurse practitioner and director of governmental affairs and research for the American Academy of Nurse Practitioners. "We've been providing primary care for 25 years, and our insurance liability rates are extremely low."

APNs are not trying to be pseudo-physicians, stressed McGinn. Their goal is not to practice medicine. APNs seek to provide health-care services that are clearly within their scope of nursing expertise and, if they so chose, to provide them independent of physician supervision, she said.

This, however, amounts to a call to political arms for the AMA, said Schwarz. "I think we're going to have a terrible political fight," he said. "It's been going on at the state level, with skirmishes here and there ... but it's reached a level where they [nurses] are challenging some fundamental assumptions on which the profession of medicine is built."

"They [ANA officials] think this is the time—in this climate of health-care reform, cost containment and [shortage] of primary-care physicians—to press their agenda. ... I've tried to tell people in leadership roles in nursing that a war is inevitable [if they continue their efforts]."

The fray is complicated by a third group—a contingent of an estimated 25,000 physician assistants (PAs). PAs perform many of the same services as APNs, but always work under the supervision of physicians.

Tradition has long lumped APNs and PAs together under the umbrella title of physician extenders, but many nurses regard the term as demeaning. APNs contend they are not extensions; they are collaborators with physicians. They point out that most APNs have a master's degree, whereas PAs can practice after they complete a 24-month training program and pass a national certification exam.

PAs square off opposite nurses in the supervision debate. The doctrine that the health-care team has one captain, and that person is the physician, is virtually dogma at the American Academy of Physician Assistants.

Physicians have a vested interest in promoting the PAs-as-captive-workforce model, said McGinn. "Physicians control everything completely with PAs; they control their practices and they control their salaries," McGinn said.

Many health-care payers—including government agencies, health insurance companies and health maintenance organizations—have virtually held APN independence hostage by funneling nurses' fees through

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War

Continued from page 1

supervising physicians who may do little more than sign-off on claim forms, said Leah Binder, director of public relations for the National League for Nursing. That required signature not only has a price—a chunk of the fee—it also "restricts entrepreneurism among nurses," Binder said.

The ticket to liberating nurses from what amounts to an economic lock-out is to directly reimburse nurses for their services, McGinn said.

The AMA's Schwarz vows that if APNs get the legislative changes they want, and throngs of them begin to hang out shingles across the street from physicians' offices, "the war will just continue."

In a protracted doctor versus APN battle, physician scrutiny of nurses likely would be the fodder, said Linda Tinson, RN, BSN, a certified nurse practitioner who works at Cook County Hospital. "This is a scary time," she said. "There are going to be a lot more eyes watching you and waiting for you to make any little mistake, so they can say, 'I told you so.'"

What nurses can do legally on their own initiative remains blurred in the minds of many APNs who want to be independent. But what if state and federal laws were enacted that spelled out the rights and practice territories of APNs? "Within two years," predicted Binder, "instead of calling your doctor when you're sick, you'll call your nurse."

Mary Peterson Kauffold is a Chicago freelance writer.

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There are challenges, though, that I wonder if I'm going to overcome. When you have a program that loses money, you always wonder if you'll have enough glue to keep things together.

The profession, which is about 25 years old, has blossomed in the last couple of years because there's a growing awareness that there are areas where there is not enough care. And, gradually, even organized medicine has begun to realize that physicians can't do everything. The quality-of-care studies that have been done are just wonderful for PA's. Malpractice claims are almost non-existent.

To be a good PA, you have to have a strong academic background. There are no programs that will take anybody directly out of high school. The courses are very rigorous, and some are taken with medical students. You have to have good academic credentials, especially in the sciences. They also prefer people with prior health-care experience because you're thrown in with patients from the beginning. You're on a team, seeing patients with a physician, a fourth-year medical student, a resident and a PA student. You've got to be a mature person. ■

Interview by free-lance writer Norma Libman.

HEALTH-CARE REFORM

In S. Dakota, problem is plain — too few doctors

State typifies the problems of medical care in rural areas

By Richard Wolf
USA TODAY

WALL, S.D. — Nestled between the Badlands and the Black Hills deep in cattle country, health-care reform is a four-letter word: Dave.

Forget managed competition, employer mandates and a menu of health plans. The ranchers and farmers out here — 30 miles from the nearest doctor and hospital — are dependent on physician assistant Dave Custis for their care.

"I do all my own X-rays, I draw all the blood, I give all the shots," Custis says, while juggling his Wall Clinic caseload of colicky infants, frail Medicare patients and occasional emergencies. "We're out here on the front line of medicine, and we don't have the technology to go with it."

The slice of rural America Hillary Rodham Clinton visits today in Lennox, S.D., needs health-care help far more basic than the complex prescriptions now under review in Washington, to solve problems far more life-threatening:

▶ Manpower. Doctors are hard to find and keep, making physician assistants, nurse-practitioners and county nurses a godsend for people in small towns. The nation has one doctor for every 400 people; in South Dakota, it's one for 600.

▶ Distances. When emergencies or illnesses are too much for those front-line medics to handle, it's not unusual for expectant mothers, accident victims or heart-attack patients to travel an hour or two to the nearest hospital.

In the 1940s, South Dakota had doctors in 165 places. Today they're at just 69 locations.

▶ Money. Rising insurance premiums and medical bills take a toll on a population dominated by the elderly, the self-employed and small businesses. Clinics and hospitals struggle to balance books, with lower federal reimbursements.

All those hardships come together in places like Wall, home of Wall Drug Store. Billboards all along Interstate 90 tout the store's 5-cent coffee and buffalo burgers.

Custis sees 6,000 patients annually and sends some an hour away to Rapid City. The clinic, which lost its lone doctor in 1991, turned a $985 profit last year — far short of the mark needed to get Custis some help.

By Matthew Kryger

ON THE FRONT LINES: Physician assistant Dave Custis examines Betty Dunker in Wall, S.D. The nation has one doctor for every 400 people; in South Dakota, it's one for 600.

"If we didn't have 'Doc,' we would be lost," says Betty Dunker, 43, who visits Custis for anything from a bad cold to treatment for multiple sclerosis. "He'll make house calls."

That's the kind of care required in rural America:

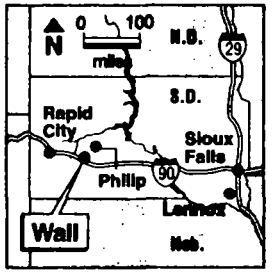
▶ It's home to one-quarter of the U.S. population, but more than one-half of all Americans living in areas officially designated as short on doctors.

▶ More than 14% of rural residents go without insurance for at least a year; 18% of farm families lack insurance.

The South Dakota story is like others. About 100,000 residents, one-seventh of the population, go "bare" — without insurance. Two-thirds of the state has a shortage of primary care.

"Health care is tentative. You can't count on it," says Sen. Tom Daschle, D-S.D., as he pilots a plane to Wall to meet with ranchers.

At the Wall Clinic, mammograms are a road show from Rapid City, a dentist stops by once a week, and orthodontia is offered every six weeks.



USA TODAY

Thirty miles east in Philip, two doctors staff a clinic, 20-bed hospital and 30-bed nursing home for the area's 3,500 people. They're the only doctors between Pierre and Rapid City, a distance of about 150 miles — and their stories illustrate the manpower problem.

▶ George Manguils, 71, is a Latvian-born doctor with a medical degree from Germany who has hunkered down in western South Dakota for four decades. Over the years, U.S.-educated doctors recruited to help him have come and gone.

"We are like a transit station," Manguils says. "We are struggling about how to make the ends meet."

▶ Coenraad Klopper, 46, is a South African doctor recruited in 1991 from Saskatchewan after battles over residency and certification. Unlike his predecessors, he has remained, but, as Manguils reduces his Klopper is overworked.

"We do anything which comes along," he says. "Out here, you're it. You don't have any off time. You can't go anywhere, you can't do anything."

To these and other rural Americans, health-care reform holds both promise and peril.

▶ Among the promises are incentives aimed at boosting the number of medical school graduates who enter primary care, placing them in rural areas and expanding the roles of non-physician providers.

▶ Among the perils are additional cuts in Medicare, which could further reduce already restrictive rural reimbursement rates, and a system of mandatory consumer purchasing groups that could prove difficult to implement in sparsely populated states.

Those new alliances — plus mandates that employers provide insurance, and price caps on insurance premiums — are supposed to create President Clinton's vision of "managed competition."

But in Wall, where there's just one physician assistant few insurance plans, there's no competition to manage.

Says Daschle, a defender of the Clinton plan: "There is a realization that you can't run South Dakota's health care program like New York or Florida would run theirs."

Assistants, nurses: same but different

Madison, WI 1-15-94

By Scott Russell

The Capital Times

Physician assistants and nurse practitioners cite two reasons for choosing their professions: They work fewer hours than doctors yet have more autonomy than many other health care professionals.

And while they are technically supervised by a physician, they say on a practical basis they are given the opportunity to work with patients one-on-one unless something unusual pops up and requires a doctor.

"I get asked: 'Don't you want to go on and become a doctor?' " said Monica Stanek-Dieter. "The answer is 'no.' I like my level of involvement with patients. I like my level of responsibility and time commitment. It's the best of two worlds."

Stanek-Dieter is a certified nurse practitioner in the DeForest satellite office of the Monona Grove Clinic.

For Nadine Kroenke, a fourth-year student in the University of Wisconsin-Madison's physician assistant program, priorities in her career choice included the pace of her daily schedule and shared responsibility.

"I don't want to feel rushed with my patients," she said. "I wanted to be part of a team. I didn't see it as a prestige thing."

When it comes to choosing between being a PA or an NP, the decision may rest with a preference for one type of training over another.

Some physician assistants claim their training is more solidly rooted in diagnosis and treatment of disease than training for nurses.

David Wilson, also a fourth-year PA student, worked 10 years as a registered nurse before making the switch. During some of those years he worked as the tranplant coordinator at University Hospital.

> 'I like my level of involvement with patients. I like my level of responsibility and time commitment. It's the best of two worlds.'
>
> MONICA STANEK-DIETER

"PAs are trained to think and act like physicians," he said. "I chose to become a physician assistant over a nurse practitioner because I wanted more training in the medical model than nursing gives you."

Under the nursing model, the diagnosis is already there, he said. "You take care of all the patient's needs, their emotional well-being. You're with them all the time."

"Nurses provide the best care," Wilson said. "They do not make the diagnosis."

Nurse practitioners would argue that they receive diagnostic training in school as well as additional education on broader health care issues.

"We do have the medical training within our curriculum," said Terri Patwell, a nurse practitioner at the Black Earth Clinic. "I also learned about health maintenance and prevention. I see our role here as keeping patients as well as they can be."

Patwell said she thought about going to school to be a physician assistant, but decided against it because in her heart she knew she was a nurse.

"The background of the nurse — we are really professional caregivers," she said. "Even though I do a lot of the same things a physician assistant does, my nursing background has influenced how I work."

DAVID SANDELL/THE CAPITAL TIMES

Lou Falligant (above), president-elect of the Wisconsin Academy of Physician Assistants, entered the field when it was just getting off the ground in the mid 1970s. Work was sporadic, but now the profession has reached its stride, Falligant said.

Those whose job it is to train physician assistants and nurse practitioners diplomatically dismiss the question of professional friction between the two fields.

"There were difficulties early on," said Forrest Girdley, head of the UW-Madison physician assistant program. "Those have largely disappeared."

Vivian Littlefield, dean of the UW-Madison's School of Nursing, said it's important to think about the contributions of both professions, "rather than whether one is better than another."

People entering either profession can expect healthy job opportunities. But that was not always the case.

Lou Falligant, president-elect of the Wisconsin Academy of Physician Assistants, entered the field when it was just getting off the ground in the mid 1970s. Work was sporadic. He ended up working in Buffalo County in central Wisconsin.

"I wrote several hundred letters looking for a job," he said. "I only got two or three responses."

But now the profession has reached its stride, Falligant said. "We have people ask us how their children can become a physician assistant. It's certainly more fun to answer that than the question: 'What's a physician assistant?' "

Physician assistants entering medical system

Continued from Page One

technologist and blood bank specialist.

"I wanted more patient contact," said Lew, a member of the Sisters of Charity. She wants to work with the poor and treat patients physically as well as spiritually.

"I'm just sorry that some of the physicians are not open-minded to the need," she added.

For years, the state Medical Society and the state Nurses Association lobbied to keep physician assistants from practicing in New Jersey, arguing that the quality of care would suffer and that it would wind up costing the health care system more to add another layer of professionals between doctors and nurses.

"Contrary to what my friends in the Medical Society think, it improves the quality of care. Our experience here has been very positive," said Dr. Fred Jacobs, president of the state Board of Medical Examiners.

The two physician assistants who have worked in neurosurgery and orthopedics at St. Barnabas Medical Center in Livingston, where Jacobs is senior vice president for medical affairs, have worked out "extraordinarily well," he said.

Some of the hospital's medical staff members were ambivalent at first, Jacobs conceded. "Now you find doctors on our staff who were opposed to this who want to hire their own PAs," he said.

Dr. Sophie Pierog, vice president and director of the pediatrics department at Jersey City Medical Center, said she too expected problems with residents, nurses and doctors adapting to the three physician assistants working there under the pilot project.

Photo by Rich Krauss

Joseph Thornton, clinical coordinator of the physician assistant program at Robert Wood Johnson Medical School in Piscataway, watches as Sister Dolores Lew of Convent Station performs an ear examination on fellow student Linda Greer of Millstone

"But we've had smooth sailing," said Pierog, who hopes to "multiply by a dozen" the one physician-assistant she has working in pediatrics.

"Any extra help is always welcome," said Dr. Michele Reisner, the director of the emergency room at Jersey City, where she supervises a physician assistant. "I certainly would welcome more PAs in the emergency room."

Physician assistants are also working at University Hospital in Newark and Cooper Medical Center in Camden. They have worked for years in Veterans Administration hospitals and prisons in New Jersey run by the federal government.

Physician assistants who led the fight to be licensed in New Jersey and state officials who have worked on implementing the new law say the year-and-a-half delay is not unusual to get a new category of health care professional working. It takes that long, here and in other states, to develop the rules and licensing procedures for a new category of professional, they said.

"It is not easy to get a license in New Jersey," Jacobs said. "I don't apologize for that. It should not be easy. I want to make sure these people who apply are who they say they are."

The 17-member Board of Medical Examiners he heads licenses physician assistants.

"While it takes a little longer, it serves the public," Jacobs said.

Nicole Gara, director of government and professional affairs at the American Academy of Physician Assistants, said some states have taken about the same amount of time and others longer. Missouri took a year and a half. The Pennsylvania Medical Board has taken seven years to rewrite its rules after a law was passed removing authority from the board of pharmacy.

It took 18 months after New Jersey passed a law allowing respiratory therapists to practice before regulations were adopted, according to Marianne Kehoe, executive director of the physician assistant advisory committee. There are about 50 physician assistant applications in varying stages of approval, Kehoe said.

Joseph Thornton, president of the New Jersey Society of Physician Assistants and one of the first five applicants to have their licenses approved, said things are not moving as fast as he would have liked but he has seen no evidence that anyone is being "obstructionist."

Ruth Fixelle, director of the Rutgers-UMDNJ physician assistant program, said she did think the delay was "really unusually long." She said the medical board had been more "cooperative and helpful than we anticipated." Fixelle was also among the first five physician assistants granted licenses earlier this month.

New Jersey graduates have scored the highest in the country over the past few years on the national physical assistant exam, but until now they have had to look elsewhere for work. There are about 300 physician assistants living in New Jersey but working elsewhere, Thorton said.

Because they are in demand – seven jobs are waiting for every new graduate nationally – New Jersey hospitals have some recruiting to do to bring back physician assistants to the state to work, a hospital association official said.

In the meantime, physician assistants are starting a new fight. They want a bill passed (A-2806/S-1943) that would allow them to get temporary licenses between the time they graduate in May, take a national exam in October and get the results back in late January.

also ran July 7, 1993 in Allied Health Section

Judge

Nelson

Patchin

Do APNs need doctor supervision?

NP, physician and PA face off

Health-care delivery is undergoing radical surgery as lawmakers and providers grapple with the need to ex access to health care without compromising the quality of patient services.

The gap between the demand for pr y care and the number of available physician providers likely will be bridged by non-physician professionals, advance-practice es (APNs) and physician assistants (PAs).

As APNs pursue a career agenda that will give them more autonomy, they are encountering opposition from both doctors and PAs who say physician supervision is essential.

How important is physician supervision of nurses and/or PAs to the integrity of the health-care system? Should APN primary-care specialists—nurse practitioners—be encouraged to work independently, that is, not under the direction of a physician?

We asked a nurse practitioner, a physician assistant and a doctor who worked as an RN for 15 years to comment on the emerging independent role of nurse practitioners. (Our panel's telephone-conference dialog has been edited for space.)

***Diane Judge, RN, MSN,** a certified primary-care nurse practitioner at the University Health Service at the University of Chicago, is chairperson of the Illinois Nurses Association Council of Nurse Practitioners, Chicago.*

***Ron Nelson,** a certified physician assistant at Cedar Springs Medical Center, Cedar Springs, Mich., is the former president of the American Academy of Physi- Assistants.*

***Dr. Rebecca Patchin,** a fourth-year resident in anesthesiology at Loma Linda University Medical Center, Loma Linda, Calif., worked as a registered nurse in critical care and pediatrics from 1969 to 1984, before entering medical school in 1985.*

Judge: Of course nurse practitioners should work independently within their scope of practice! Supervision of nursing functions by a physician is not necessary. Collaboration with a physician, however, for practical purposes, is always necessary, unless a nurse is performing only nursing functions.

There are some areas of overlap (of nursing care and physician care), but I don't think supervision is necessary. There are many studies that show that.

Nelson: Nursing activities are best defined by the nursing profession itself. My belief—and the belief of the PA profession—is that the practice of medicine by PAs requires the supervision of a physician. And that supervision should be defined by the physician, the PA and the state's practice code.

Patchin: I think there are some (nursing functions) that may not require direct physician supervision. Incidentally, I personally prefer the terms collaboration and collaborative practice.

Above all, we must remember that each patient is a whole person and that we can't divide a human being into separate territories of nursing practice (and) medical. . . . It's sometimes difficult to define where the nurse's scope of practice and the physician's scope of practice begins and ends.

But if there are times when collaboration is indicated and necessary, then I think we've answered the question: "Should nurses work independently?" I say no.

Judge: I'm sort of uncomfortable that we're (debating) independent practice by nurses, even though nurses are out in rural areas (where physicians are scarce) and practicing independently right now—and that's okay.

Patchin: The quality of care should be the same for everyone, whether they live in a rural community, or an affluent suburban community, or an inner-city ghetto. . . . The best way to consistantly deliver quality health care is for all parties—doctors, nurses and PAs—to sit down together and agree on the scope of practice for each, which may depend upon the skills of the individual as well as the practice setting.

Nelson: One of the problems that we've experienced is what I refer to as the smoke and mirrors of collaboration and supervision . . . Hopefully, we all know what our limitations are, and that's what makes us adequate and good professionals.

We're all interested in promoting better delivery of health-care services, and that requires someone to be the head of the team. Someone has to be the captain of the ship. Obviously the physician, in terms of education and background, is the individual to provide that kind of direction and supervision.

Judge: Nurse practitioners are not proposing to do medical care. We are providing health care. Incidentally, I just have to get on record as saying I don't agree with the doctrine that the captain of the ship is the physician.

Reporter: Who is better prepared to provide primary care, a nurse practitioner who is working without direct supervision or the physician assistant who is always under a physician's supervision?

Patchin: Obviously, it's nice to have things black and white. I personally don't see that you can say who is best and who is worse. You have to look at the educational preparation and the situation.

Nelson: I really don't think education is the issue. The issue is the (provider's) qualifications to completely take care of patients. PAs are trained in the physician model; they're trained to manage patients using the same approaches that are taught to physicians.

Judge: I don't think we have to decide who's best prepared to give care. The fact is there are not enough primary-care providers.

Nelson: The bottom line is the safe practice of medicine by PAs requires a supervisory relationship. And that supervisory relationship is determined by state law, the physician and the practicing PA.

The team approach to health care is still the most effective model for delivery of health-care services. . . . PAs are part of equation.

Judge: (Expanded) primary health-care services are basic to effective health-care reform . . . What's really important to nurse practitioners, so we can continue to provide access to that care, is fessional recognition, (which includes) prescriptive authority direct reimbursement.

Patchin: I worked (as an RN) in a physician's office for a year with a family practicer and a pediatrician, and was using some on-the-job training skills at that time to do pediatric well-baby checks and female physical assessments . . . When I looked at my future life and career, I made a decision to go (to medical school), rather to go into advance-practice nursing. That was a conscious decision. And it was based on my belief then, and my continuing belief, that the physician is the captain of the ship.

We need to ensure that our citizens have access to quality health care. I believe the best to ensure that is through a or collaborative approach. And to that does not mean having independent (APN or PA) practices.

Interviews by Mary Peterson Kauffold RN, a Chicago freelance writer.

Target: Issue

'War' looms as APNs seek independence

Chicago Tribune June 30, 1993, Special Section

By Mary Peterson Kauffold, RN

Advance-practice nurses are determined to shed the last vestige of their physician handmaiden image and win the respect, autonomy and remuneration that they say still eludes them—even if it takes an act of congress in the name of health-care reform.

Both physician and nurse groups are marshalling their member forces in what may be the most volatile health-care turf battle in a long time.

At issue "is money and control," said Nancy McGinn, RN, MSN, a certified nurse practitioner who is a staff specialist in workplace advocacy for the American Nurses Association.

The ANA's position is clear: The time is long overdue to make prescriptive privileges and direct reimbursement for services legal nationwide for advance-practice nurses (APNs), who count among their ranks about 30,000 nurse practitioners, 5,000 nurse midwives, 40,000 clinical nurse specialists and 25,000 nurse anesthetists.

The ANA solution to the shortage of primary-care providers is simple: Rethink the definition of provider. "Some 60 to 80 percent of primary and preventive care traditionally done by doctors can be done by [an APN] for less money," asserts an ANA publication.

"That's where the rubber hits the road," said Dr. M. Roy Schwarz, senior vice president of medical education and science at the American Medical Association. "That's where the professions sharply divide. We'll forever be divided on that issue, because medicine believes nurses are not adequately trained to play the role of doctor."

"The quality-of-care argument just doesn't hold water," said Jan Towers, PhD, a certified nurse practitioner and director of governmental affairs and research for the American Academy of Nurse Practitioners. "We've been providing primary care for 25 years, and our insurance liability rates are extremely low."

APNs are not trying to be pseudo-physicians, stressed McGinn. Their goal is not to practice medicine. APNs seek to provide health-care services that are clearly within their scope of nursing expertise and, if they so chose, to provide them independent of physician supervision, she said.

This, however, amounts to a call to political arms for the AMA, said Schwarz. "I think we're going to have a terrible political fight," he said. "It's been going on at the state level, with skirmishes here and there . . . but it's reached a level where they [nurses] are challenging some fundamental assumptions on which the profession of medicine is built."

"They [ANA officials] think this is the time—in this climate of health-care reform, cost containment and [shortage] of primary-care physicians—to press their agenda. . . . I've tried to tell people in leadership roles in nursing that a war is inevitable [if they continue their efforts]."

The fray is complicated by a third group—a contingent of an estimated 25,000 physician assistants (PAs). PAs perform many of the same services as APNs, but always work under the supervision of physicians.

Tradition has long lumped APNs and PAs together under the umbrella title of physician extenders, but many nurses regard the term as demeaning. APNs contend they are not extensions; they are collaborators with physicians. They point out that most APNs have a master's degree, whereas PAs can practice after they complete a 24-month training program and pass a national certification exam.

PAs square off opposite nurses in the supervision debate. The doctrine that the health-care team has one captain, and that person is the physician, is virtually dogma at the American Academy of Physician Assistants.

Physicians have a vested interest in promoting the PAs-as-captive-workforce model, said McGinn. "Physicians control everything completely with PAs; they control their practices and they control their salaries," McGinn said.

Many health-care payers—including government agencies, health insurance companies and health maintenance organizations—have virtually held APN independence hostage by funneling nurses' fees through

See War, pg.2

War

Continued from page 1

supervising physicians who may do little more than sign-off on claim forms, said Leah Binder, director of public relations for the National League for Nursing. That required signature not only has a price—a chunk of the fee—it also "restricts entrepreneurism among nurses," Binder said.

The ticket to liberating nurses from what amounts to an economic lock-out is to directly reimburse nurses for their services, McGinn said.

The AMA's Schwarz vows that if APNs get the legislative changes they want, and throngs of them begin to hang out shingles across the street from physicians' offices, "the war will just continue."

In a protracted doctor versus APN battle, physician scrutiny of nurses likely would be the fodder, said Linda Tinson, RN, BSN, a certified nurse practitioner who works at Cook County Hospital. "This is a scary time," she said. "There are going to be a lot more eyes watching you and waiting for you to make any little mistake, so they can say, 'I told you so.'"

What nurses can do legally on their own initiative remains blurred in the minds of many APNs who want to be independent. But what if state and federal laws were enacted that spelled out the rights and practice territories of APNs? "Within two years," predicted Binder, "instead of calling your doctor when you're sick, you'll call your nurse."

Mary Peterson Kauffold is a Chicago freelance writer.

Special Communication

Physician Assistants and Health System Reform

Clinical Capabilities, Practice Activities, and Potential Roles

P. Eugene Jones, PhD, PA-C, James F. Cawley, MPH, PA-C

NATIONAL efforts to reform the health care system will likely result in changes in the roles and responsibilities, practice combinations, and distribution of health professionals, including midlevel providers such as physician assistants (PAs), nurse practitioners (NPs), and certified nurse-midwives. Although recent studies have addressed differing scenarios of the projected roles of midlevel providers,[1-5] implementation of initiatives that involve PAs may be influenced by an overall shortage of PAs, existing barriers to PA practice, and the need for commitment to physician-dependent practice relationships in a team-oriented health care delivery system. This article reviews the history, academic preparation, clinical capabilities, distribution, and practice activities of PAs and discusses the potential roles of PAs in the changing health system environment.

The origin of the PA can be traced to the new health practitioner movement of the 1960s, during which the PA concept emerged from a combination of events. As experienced hospital corpsmen and combat medics returned from service in Vietnam, there were no civilian job equivalents or suitable health career pathways in the United States. Simultaneously, a new health care provider model proposed in 1961[6] resulted in the development of the first PA program at Duke University School of Medicine. According to this concept, PAs "would be trained to assist the doctor . . . in such a way as to facilitate better utilization of available physicians and nurses."[7] These circumstances eventually resulted in the matriculation of substantial numbers of military veterans into newly developing PA programs. Subsequently, more PA programs were developed to train providers who would (1) augment the capabilities of primary care physicians by increasing access to basic medical care services, (2) fill service gaps resulting from geographic and specialty maldistribution of physicians, and (3) help control health care costs.[8,9]

From the Physician Assistant Program, Department of Health Care Sciences, University of Texas Southwestern Medical Center at Dallas (Dr Jones), and the Physician Assistant Program, Department of Health Care Sciences, The George Washington University, Washington, DC (Mr Cawley).

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PA EDUCATION

By 1993, there were 58 accredited PA programs in 29 states and the District of Columbia and 27 403 program graduates.[10,11] With the exception of a few hospital-, military-, and community college–based programs, the majority of PA programs are affiliated with academic health centers (AHCs), medical schools, or 4-year colleges and universities, 26% of which are classified as category I research universities by the Carnegie Foundation for the Advancement of Teaching.[12] Thirty-five PA programs (60%) offer a baccalaureate degree or degree option, 12 (21%) offer master's degrees, and the remainder grant an associate degree or a certificate of completion.

Essentials for PA Education

The "Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician" were initially adopted in 1971 by the American Medical Association in collaboration with the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Society of Internal Medicine.[13] Following the organization of the Committee on Allied Health Education and Accreditation in 1977, the Essentials were revised in 1978, 1985, and 1990. The Essentials establish minimum standards of quality to which accredited programs are held accountable. After the Essentials initially were adopted, federal funding acts supported the expansion of PA educational programs' emphasis on a primary care orientation for preparing generalist PAs.[14]

According to the current Essentials of the Committee on Allied Health Education and Accreditation, PAs are "academically and clinically prepared to provide health care services with the direction and responsible supervision of a doctor of medicine or osteopathy. The functions of the physician assistant include performing diagnostic, therapeutic, preventive and health maintenance services in any setting in which the physician renders care, in order to allow more effective and focused application of the physician's particular knowledge and skills."[15(p6)]

Clinical services performed by PAs are described by the Essentials in the following six categories[15(pp6-7)]: (1) *evaluation*—initially approaching a patient of any age group in any setting to elicit a detailed and accurate history, perform an appropriate physical examination, delineate problems, and record and present the data; (2) *monitoring*—assisting the physician in conducting rounds in acute and long-term inpatient care settings, developing and implementing patient management plans, recording progress notes, and assisting in the provision of continuity of care in office-based and other ambulatory care settings; (3) *diagnostics*—performing and/or interpreting, at least to the point of recognizing deviations from the norm, common laboratory, radiological, cardiographic, and other routine diagnostic procedures used to identify pathophysiological processes; (4) *therapeutics*—performing routine procedures such as injections, immunizations, suturing and wound care, management of simple conditions produced by infection or trauma, and assistance in the management of more complex illness and injury, which may include assisting surgeons in the conduct of operations and taking initiative in performing evaluation and therapeutic procedures in response to life-threatening situations; (5) *counseling*—instruction

and counseling of patients regarding compliance with prescribed therapeutic regimens, normal growth and development, family planning, emotional problems of daily living, and health maintenance; and (6) *referral*—facilitating the referral of patients to community health and social service agencies when appropriate.

Curriculum Content

Prior to matriculation, the typical PA program requires the student to have completed the equivalent of 2 years of undergraduate-level biological, social, and behavioral science prerequisites. The first 9 to 12 months of PA education are devoted to preclinical didactic studies and include courses in anatomy, physiology, microbiology, pharmacology, psychology, clinical medicine, physical diagnosis, preventive medicine, and clinical laboratory procedures.[16] Courses in the basic medical sciences account for 77% of the didactic component of PA education, with the remainder devoted to behavioral and social sciences. Educational programs for PAs average more than 1004 contact hours of didactic instruction.[17] These courses are typically followed by 9 to 15 months of physician-supervised clinical education in both inpatient and outpatient settings in urban, inner-city, and rural communities.

In some AHCs, didactic PA education and medical student education is conducted with shared classes and resources, and PA students typically are educated in a clinical setting by residents, attending physicians, and graduate PAs. Most programs include supervised clinical educational experiences for PA students in rural or medically underserved areas. In addition, several hospital- and university-based postgraduate courses of instruction exist in medical and surgical specialties such as neonatology, pediatrics, emergency medicine, occupational medicine, and surgery.

Primary Care Deployment Models

A number of PA programs have developed specialized curricula designed to promote primary care practice in underserved communities, including content on substance abuse education for health professionals, geriatrics, mental health, health care for the homeless, women's health initiatives, environmental/occupational medicine, medical Spanish, and a general orientation toward prevention in the delivery of health care.[14] Many programs have successfully placed graduates in chronically underserved areas via decentralized educational projects.[18,19] For example, participants in the Stanford University Primary Care Associate Program were twice as likely to be employed in rural communities (<10 000 population) as nonparticipants (33% vs 16%).[20] A 1992 survey of participants in the University of Nebraska PA Program's Rural Health Opportunities Project revealed a similar graduate employment rate (33.4%) in communities with fewer than 10 000 population.[21] More recently, a satellite educational project developed by the University of Washington–MEDEX Northwest Physician Assistant Program provides on-site didactic and clinical education for rural and Native Alaskan matriculants in Sitka, Alaska, and additional MEDEX Northwest projects link the University of Nevada and Boise State University with area health education centers for rural PA deployment.

Several PA programs have developed master's degree majors for PAs who will serve underserved populations and areas of special need. Graduate PA programs in rural health are offered at Alderson-Broaddus College in Philippi, WVa, and the University of Nebraska–Omaha. Public health education is offered in combined PA/MPH programs at The George Washington University, Washington, DC, and the University of Oklahoma in Oklahoma City, and a combined PA/MS degree in preventive medicine is offered at the University of Iowa in Iowa City.

AHC-Affiliated PA Programs

Of the 58 accredited primary care PA programs, 27 (47%) are sponsored by AHCs. Twice as many AHC-based PA programs receive federal grant support as non–AHC-based programs, and at a 12% greater dollar amount than non–AHC-based PA programs. Because federal PA training grants are tied to demonstrated success in primary care education and graduate placement in health professional shortage areas, it follows that AHC-sponsored PA students spend more time in primary care–based clinical education and are employed in primary care settings at a greater rate than non–AHC-sponsored students.[22] Consequently, AHC-based PA programs may be better positioned than non–AHC-based programs to contribute to the goals of the Health of the Public Program[23] by providing interdisciplinary didactic and clinical education in population-based competencies, by continuing emphasis on health promotion and disease prevention activities,[24] and through PA faculty service and student rotations that augment community access to health care services.

Funding Sources

In 1993, 33 PA programs received a total of $6.65 million in federal training support under Title VII authorization through the Health Resources and Services Administration Grants Program for Physician Assistants of the Public Health Service, administered by the Division of Medicine. In the same year, the mean PA program budget was $457 000 and the average Title VII grant award was $143 000, which accounted for 28% of program operating costs.[22] Fiscal year 1995 authorization is $9 million.

Title VII funding preferences and priorities for PA program education grants have traditionally emphasized primary care education and deployment, affiliation with graduate programs in family medicine, and strategies for increased enrollment and retention of underrepresented minorities. Funding preferences and priorities for the fiscal year 1994 application cycle address medically underserved community practice, generalist specialty practice, and increased enrollment of minorities or low-income applicants.

From the inception of PA educational programs, internal support from sponsoring institutions has increased steadily while external (primarily federal) support has remained at about one third of total program revenues. This trend reflects increasing self-sufficiency on the part of PA programs, because the level of federal support during the past 7 years has remained relatively constant.

The overall cost of PA education remains relatively low. The average total cost for educating a PA student is approximately $8029 per year at AHC-sponsored programs and $7546 per year at non–AHC-sponsored programs.[22]

Response to Federal Initiatives

Educational programs for PAs have responded to federal grant initiatives by specifically targeting curriculum content toward primary care for medically needy populations. This includes special focus on topics such as the acquired immunodeficiency syndrome, substance abuse, adolescent pregnancy, childhood immunizations, risks of cancer and heart disease, and reduction of infant mortality. More than half of all PA programs have developed specific educational content to address the health and medical problems of inner-city populations. Most PA programs have developed strong linkages with area health education centers, community education centers, rural health clinics, community/migrant health centers, and other primary health care agencies and settings. Fellowships for PAs in migrant health centers are jointly sponsored by the Health Resources and Service Administration, National Rural Health Association, American Academy of Physician Assistants, and Association of Physician Assistant

Table 1.—Physician Assistant Specialty Distribution, by Percentage, 1974 Through 1993*

Specialty	1974 N=939	1978 N=3416	1981 N=4312	1984 N=6552	1987 N=10 692	1993 N=14 746
Family practice	43.6	52.0	49.1	42.5	38.7	34.5
General internal medicine	20.0	12.0	8.9	9.2	9.5	9.5
General pediatrics	6.2	3.3	3.4	4.1	4.0	2.3
General surgery	12.1	5.5	4.6	5.1	8.8	6.4
Surgical specialties	6.8	6.2	7.7	12.5	13.8	20.6
Medical specialties	3.9	6.3	2.7	4.8	7.1	6.0
Emergency medicine	1.3	4.9	4.5	6.4	6.5	8.2
Occupational medicine	1.8	2.7	3.1	4.1	4.1	3.1
Other†	4.3	7.1	16.0	11.3	7.5	9.4

*Sources of data are references 10 and 29.
†Other includes pediatric specialties, physical and rehabilitation medicine, psychiatry, public health, and radiology (all <1%); 3.3% were not identified.

Programs to promote PA practice in migrant health settings.

Faculty

Educational programs for PAs experience difficulty in identifying, recruiting, educating, and retaining sufficient numbers of qualified faculty members. The combination of an enlarging applicant pool, pressure to increase the number of PAs trained per program, and an increasing number of clinical employment opportunities has resulted in an "academic hourglass" effect, further complicated by an already insufficient supply of experienced PA educators. Because of the disparity between academic and clinical income potential, faculty positions designed as joint teaching–practicing clinician positions are commonplace means of income supplementation. Sixty-nine percent of PA faculty are concurrently engaged in part-time clinical practice, averaging 10 hours per week, earning an average wage of $26.29 per hour.[25]

As with most professional schools, no formal pathway exists for PA-specific educator training. Clinically experienced PAs are typically self-referred or recruited into PA education, usually with little or no formal preparation in the foundations of educational theory and practice.[25] Of the PA program personnel identified as faculty in 1993, 13.6% held doctorate degrees, 35.2% held master's degrees, and 49.2% held bachelor's degrees. The remaining 2% held associate degrees (1%) or were not reported.[22]

Applicants and Students

As with other health professions, interest in PA education continues to increase. In 1988, PA programs averaged 86.1 applicants for 25.9 seats. By 1992, the number of applications increased to an average of 203 per PA program (an increase of 136%), and the number of enrolled students increased to 35 per program.[22] Preliminary reports of the 1994 applicant pool indicate that many programs have nearly twice the number of applicants compared with 1993.

The typical student entering PA training is a 26-year-old white woman with a 3.1 grade point average and more than 4 years of previous health care experience. Since 1984, women have constituted more than 60% of enrolled PA students, and since 1987, ethnic minorities have represented about 20% of matriculants. Most students enter PA education with either a baccalaureate degree or substantial course work in the premedical sciences. An increasing number of matriculants (7.2% in 1993) hold master's or doctoral degrees.[25]

CLINICAL SERVICES AND SETTINGS

At present, approximately 23 350 PAs are employed in clinical practice in 49 states and the District of Columbia. Trends in practice patterns of recent PA program graduates reveal increased numbers in inpatient and institutionally based settings and, until recently, fewer entering primary care practice. In 1993, 44% of PAs were employed in primary care settings, defined as family or general practice, general internal medicine, or general pediatrics (Table 1). The largest share, 34.5%, worked in family or general practice.[10] The 28% of PAs employed by hospitals included more than 6% in outpatient clinic practice (Table 2).

The distribution of PA practice settings is geographically disproportionate. Fewer recent graduates of PA programs in eastern states entered primary care practice settings (54.4%) compared with graduates in central (73.8%) and western states (70%). Seventeen percent of PAs practice in communities with a population of fewer than 10 000, and 34% practice in communities with a population of fewer than 50 000. More than 86% of all graduate PAs remain in full-time clinical practice.[10]

Changing Profiles

The demographic profile of PAs has changed markedly since the profession's inception. Although it remains a relatively young profession (the mean age of PAs is 40 years), the proportion of women PAs is now more than 42%, increasing from less than 10% in the 1970s. Almost 10% of PAs are ethnic minorities, and more than 32% are military veterans.[10]

Nearly 35% of all PAs are employed in private physicians' practices (either solo or group) and 28.5% practice in hospitals, with other PAs distributed in health care settings such as managed care organizations (7.3%), the military (4.6%), rural clinics (4.7%), Department of Veterans Affairs facilities (4.2%), and correctional facilities (2.5%). The remainder practice in nursing homes, inner-city clinics, and other clinical settings. Notable employment trends reveal fewer PAs in family medicine and more PAs in medical and surgical subspecialties (Table 1). The proportion of PAs employed in hospital settings reflects a relatively stable distribution over the past decade (Table 2).[27]

While PA practice settings continue to diversify, the largest percentage remain employed in primary care. A number of the same socioeconomic factors that discourage physicians from practicing primary care may influence PA employment decisions as well.[8] Despite the fact that most PAs are in primary care practice, it is clear that specialty and institutional employers are competing for PA services, and the patterns of diversification and specialization of PA employment further complicate an imbalanced educational supply and occupational demand mismatch.[28]

Income

As demand for PA services has grown, salaries in both primary care and specialty settings have increased accordingly. In 1993, the mean annual salary for PAs in all practice settings and specialties was $53 500, excluding fringe benefits and part-time income. Those employed in surgical specialties earned an average of $60 800 per year.[29] In a 1991 study of 6228 PAs, with the exception of those in practice less than 1 year, salaries among men were approximately $5000 greater than among women, even after controlling for clinical specialty, number of years in practice, number of patient visits per week, and number of hours worked per week.[30]

PA Productivity and Cost-effectiveness

The potential roles to be assumed by PAs in health system reform will likely correlate with their productivity and cost-effectiveness. Outcomes will differ from practice to practice, depending on variables such as the specialty, setting, and barriers to employment. The productivity and cost-effectiveness of PAs have been described and measured by the time spent per visit, average num-

Table 2.—Trends in Physician Assistant Practice Settings, by Percentage, 1981 Through 1993*

Practice Setting	1981 N=4312	1984 N=6552	1987 N=3309	1993 N=14 746
Private office†	35.8	34.5	33.2	34.6
Hospital	29.5	31.3	28.6	28.5
Ambulatory clinic‡	24.9	17.7	17.0	20.4
Health maintenance organization	NA§	NA	6.9	7.3
Military	9.4	7.3	7.6	4.6
Other‖	0.4	9.2	6.7	4.6

*Sources of data are references 10 and 29. Data for 1987 are from reference 29 only.
†Either solo or group practice.
‡Includes community-based public, privately sponsored, inner-city, substance abuse, student health, correctional medicine, and rural health clinics.
§NA indicates not available.
‖Other includes Veterans Affairs (4.2%) and nursing homes (0.4%).

ber of visits per unit of time, number of office visits or procedures, charges generated, overhead reduction, and increased physician activity.[4,31-34] In 1993, outpatient-based PAs saw an average of 22.1 patients per day, compared with an average of 15.7 patients per day for inpatient-based PAs.[10] Although many variables are influenced by the actual practice setting, the evidence suggests that physicians can increase their practices' output by employing PAs, and PAs "are capable of carrying substantial proportions of the workloads of primary-care physicians."[4(p43)]

Quality of Care

Indicators of the quality of care provided by PAs have been measured by comparing processes and outcomes between physician- and PA-provided care with regard to functions performed by both. Within their areas of competence, PAs have been shown to provide care indistinguishable in quality from care provided by physicians.[4,35] Indirect indicators of quality, such as physician acceptance and patient satisfaction, have also been favorable.[36,37] However, existing quality-of-care studies of midlevel providers have recently been criticized for being dated and methodologically flawed.[38] The need for current data derived by rigorous health services research methods is clearly indicated.

Responsibility and Accountability

State legislation governing PA scope of practice exempts PAs from the unlicensed practice of medicine with the stipulation that they function under the supervision of a licensed physician. Legally, the physician-PA relationship is one of *respondeat superior*, wherein the physician is liable for exercising care in the selection and supervision of the PA, has the right of control of the assistant, and is "liable for the negligent acts of employees performed within the scope of the employment relationship."[39(p102)] Although the supervising physician retains "vicarious liability," PA practice accountability has progressed from a delegatory model achieved by amending medical practice acts to a regulatory/authority model, wherein state licensing boards are authorized to govern PA practice. These amendments and exemptions establish PAs as the agents of their supervising physicians, and PAs maintain direct liability for the services they render to patients. Supervising physicians, who define the standard to which PA services are held, are vicariously liable for services performed by their PAs under the doctrine of *respondeat superior*.

COMPARING PAs AND NURSE PRACTITIONERS

A recent study estimated there are 27 226 NPs, distinguished from other registered nurses by state boards of nursing data. Exact numbers are unknown because of overlapping NP titles, specialty practice roles, and differing state requirements for NP education and accreditation.[40] The majority of NP practice settings were reported in family and adult medicine, pediatrics, and women's health.

A 1993 study of 51 midlevel provider educational programs (22 NP, 20 PA, two combined PA/NP, and seven certified nurse-midwife programs) compared legal, professional, and political differences between PAs and NPs.[19] Although varying degrees of differences and similarities were reported between PA and NP educational programs, the main distinction in their orientation to health care is that NP programs are typically set within schools of nursing, with education provided in the nursing model. In contrast, PA programs are typically affiliated with medical schools, with education provided primarily by physicians. However, these differences are less distinct in some regards; physicians contribute to NP education, and NP and PA educators often "cross-teach" between and among programs. In California, two programs jointly train PAs and NPs within the same department, and approximately one third of California PAs are also nurses.[41]

Although PA and NP clinical roles within managed care organizations and ambulatory settings are often regarded as interchangeable, reports comparing PA and NP productivity have differed in their findings. One study reported that both groups saw similar numbers of ambulatory adult patients in a large managed care setting,[42] whereas another reported that PAs had more direct patient encounters and generated twice the gross dollar income per day when compared with NPs.[43] These differences were not fully accounted for but were partially attributed to the tendency for NPs to spend more time providing counseling services. Debate continues on the practice productivity advantages and disadvantages between PAs and NPs, but researchers appear to agree that the potential for increased productivity for both groups is greater in larger practices and managed care settings. Nevertheless, both PAs and NPs directly reflect physician levels of task delegation in their clinical productivity.[4]

The practice of PAs is regulated under states' Medical Practice Act provisions and is based on physician supervision and task delegation, whereas NPs practice under nursing licensure provisions of Nurse Practice Acts. Research evidence clearly shows that the tasks described and roles performed by PAs and NPs are more similar than different in many ambulatory practice settings, but two major issues serve to differentiate the professions: (1) their general orientation to health care and (2) the desire for independent (NPs) vs dependent (PAs) practice relationships with physicians.[44] This divergence may have important implications for both professions if health reform measures include greater roles for PAs and NPs in private practices, managed care systems, and institutional settings.

POTENTIAL ROLES OF PAs

Under federal aegis, increasing attention is now focused on a generalist-provider–oriented system of health care. However, the projected roles of PAs in such a system are still undetermined. According to the US Public Health Service, PAs "have become firmly established as a provider group well suited to address problems of maldistribution of physicians and enhancing cost-effectiveness of care," and increasing demand for PA services was attributed to the revitalization of the National Health Service Corps, liberalization of authority to prescribe, and the increased use of PAs in hospital-based settings as a means of cost-control.[45(p7)] What remains to be seen is the level of demand and the clinical practice settings in which PA services will be required.

The federal government reinforces the

primary care focus of PA program curricula by awarding Title VII training grants for programs demonstrating a record of successfully meeting primary care–oriented funding preferences and priorities. However, the possible redistribution of medical and surgical subspecialty residency educational positions recently recommended to Congress by the Physician Payment Review Commission (PPRC) and the Council on Graduate Medical Education may result in increased use of PAs and other midlevel providers in inpatient specialty settings. This may occur as a result of a PPRC-projected loss of 11 000 residency slots.[46] Among the PPRC recommendations was a call for increased funding for specialty-trained PAs and other midlevel providers to maintain levels of inpatient care previously provided by residents. Another report reinforced this proposal, suggesting a need to determine "the extent to which nurse practitioners and physician assistants can substitute for and enhance both generalists and specialists. . . ."[2(p1073)]

The PA profession realizes increasing opportunities in medical and surgical specialty practice, and the 77% of PA programs that are federally funded are obligated to maintain generalist-based curricula. Although many newly graduated entry-level PAs are initially employed in specialty settings, the more plausible solution to the potential demand for more specialty-trained PAs may be to increase the number of postgraduate and master's level specialty programs. The projected number of PAs who will graduate in 1994 is 2100. If Title VII educational grants increase as projected, approximately 3300 PAs would graduate in 1996, followed by 3800 graduates in 1997. The annual PA graduation rate would increase to approximately 4000 by the year 2000, resulting in a total of approximately 41 000 PAs in practice. This number includes the assumption of a 1% to 3% attrition rate and the remaining years of expected practice, given the mean PA age of 40 years.[47] However, the distribution of PA practice settings will likely be influenced by a combination of market forces and reform initiatives.

Hospital-Based PAs

As the proportion of PAs working in primary care practices declined during the 1980s, the proportion of hospital-based PAs remained relatively stable. However, the distribution of PAs within hospital settings has changed, from fewer PAs in hospital-based outpatient clinics to more PAs in inpatient service roles. While PAs employed in the surgical subspecialties increased from 7.7% in 1981 to 21.7% in 1993, PAs employed in hospital settings ranged between 28% and 31.3% (Table 2). By 1992, 48.6% of practicing PAs indicated at least some inpatient care responsibility.[48] In many teaching hospitals, a combination of residency program retrenching, curtailed availability of international medical graduates, and cost-control measures has contributed to expanded inpatient roles for PAs. As a result, PA use in inpatient care roles in a wide variety of hospital settings has become commonplace.

A recent study of 1690 hospital-based PAs revealed that 45% held the job title of or were identified as "house officers." More than 90% had formal medical staff privileges and were credentialed under hospital bylaws. Their practice distribution included 19.4% in surgical subspecialties, 18.6% in medical specialties, 14.8% in emergency medicine, and 9.5% in general surgery.[48] Although the study was inconclusive in determining the levels of resident physician/house officer substitution performed by hospital-based PAs, the authors recognized the need for additional PA education in liability protection and risk management and additional research in levels of responsibility, outcomes, and privileging issues.

PAs and Managed Care

The increasing management by for-profit corporations and the economies of scale realized by capitated managed care organizations require careful cost-benefit considerations in provider ratio and distribution decisions. However, many variables contribute to differing levels of PA role and distribution settings within managed care organizations. Although managed care PAs assume a range of duties in a variety of clinical settings, it appears that physician attitudes toward PAs play a major role in staffing decisions; thus, midlevel provider distribution among similar settings within the same organization can differ significantly.[48]

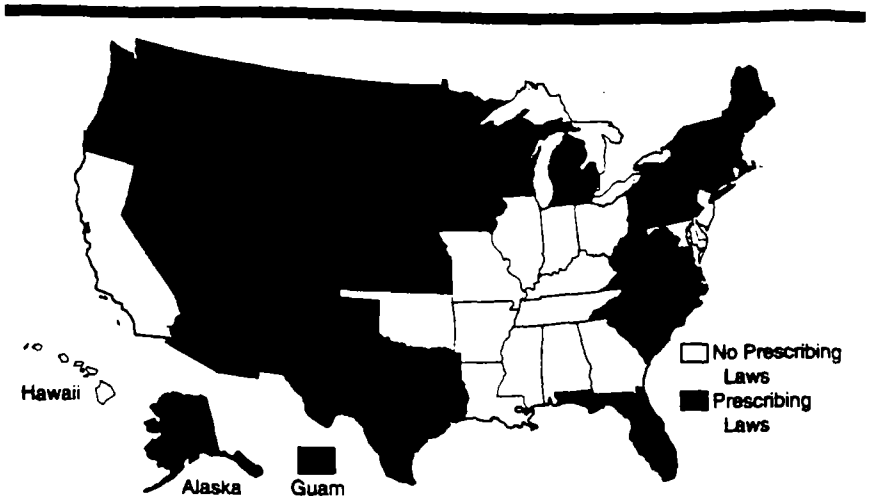
In ambulatory managed care settings, PAs have been shown to be capable of handling approximately 80% of the health care services required to manage patient problems at physician-equivalent levels of patient satisfaction and quality of care.[49] This finding is consistent with observations made in rural private practices, urban ambulatory care clinics, and geriatric settings.[19] In a large group-model health maintenance organization, physicians and PAs were found to see a similar number and type of adult ambulatory patients on an hourly, daily, and annual basis, and PAs were employed at approximately 50% of physician costs.[49] However, additional and more recent data are needed to determine frequency and appropriateness of PA consultation and referral activities, prescribing habits, rate and frequency of patient return visits, comparable degrees and mix of patient difficulty, and the amount of "nonbillable" physician time spent in consultation and supervision of PAs within such settings. In the absence of these data, the evidence indicates that, in organized ambulatory care practices where team approaches and structured division of staffing are present, PA clinical productivity compares favorably with that of physicians.[49]

BARRIERS TO PA PRACTICE

In 1993, PAs were recognized as health care providers by the medical licensing boards of 49 states and the District of Columbia; Mississippi is the only state that does not recognize PAs. State legislative and regulatory agencies maintain control over the patterns of utilization of PAs through their authority to license and regulate the profession. Barriers to enhancing the use of nonphysician health care providers were recently reported as professional territorialism, licensure restrictions, educational isolation, physician resistance, and institutional inertia.[3] These barriers vary geographically, as well as between and among differing nonphysician provider professions. As a means of reducing these barriers and encouraging change in health care delivery, the Office of the Inspector General called for an increased emphasis on supervisory and management skills in curricula for health care educational institutions and the development of cooperative practice models among different health care professions. A combination of population demographics and regulatory and reimbursement policies appears to have the greatest influence on PA practice favorability, particularly in states with disproportionate rural or medically underserved communities. However, current data that more clearly define regional and national barriers to PA practice are needed if health system reform plans include an increased use of PAs.

PA Supervision

The physician-PA employment relationship has been and is intended to remain a dependent one. The fundamental elements of PA practice (use of a referral system, frequent consultation, and periodic review) are said to be synonymous with a well-designed health system.[50] The PA's ability to consult with and refer to the supervising physician is the key factor to a successful workplace relationship, and studies suggest that the task delegation and supervision behaviors of the physician have the greatest influence on PA clinical productivity.[51] Geographic practice isolation in rural and frontier



Physician assistant prescribing authority, 1993.

settings may by necessity result in varying degrees of off-site physician supervision of the PA, and this physical separation requires a certain amount of autonomous judgment, particularly when the PA is the only available on-site provider. Regulatory reluctance to support such relationships in satellite and remote settings restricts the ability of PAs to provide needed services that might otherwise be unavailable.

Prescriptive Authority

A total of 35 states, the District of Columbia, and Guam authorize PAs to prescribe medications, but a nucleus of states do not. The cluster of 12 states (Figure) represent approximately 37% of the total US rural health professional shortage areas.[52] Although prescriptive authority varies from state to state and ranges from using protocol-based formularies for noncontrolled substances to prescribing controlled substances, PA prescribing must be done with the agreement and supervision of the physician. Patterns observed in rural PA practice in Texas reveal an example of the potential effect of prescriptive authority to increase the capabilities of PAs to improve access to care. Prior to PA prescriptive legislation passed in 1991, Texas had 26 rural health clinics. By November 1992, the number had nearly quadrupled, increasing to 99. During the same period, the percentage of Texas PAs practicing in rural areas tripled, from 5% to 15%.[53,54]

Reimbursement Issues

Variation in state laws regarding compensation for PA-provided services has also influenced PA deployment. For example, successful implementation of the Rural Health Clinic Services Act (Public Law 95-210), which provides for criteria-specific Medicare and Medicaid reimbursement for PA services, is hindered in some states by variations in the scope of their practice laws governing PAs. The practice of PAs is also complicated by state-by-state Medicaid reimbursement policies that remain inconsistent. The services of PAs are governed by the "incident to" provision, which allows for reimbursement at the physician fee level for office or clinic services provided by the physician's staff that are considered integral, although incidental, to the physician's services. The physician must be present when the PA-performed services are delivered, and the PA's services are billed and paid for as if the physician had performed them. Differing states' interpretations of the incident to physician service clause of Medicare and its carriers confuse PA employers regarding reimbursement for services provided by PAs, especially where on-site supervision is not always required, and where PAs are hired by practices for the specific purpose of extending medical services to rural and underserved communities.

Although Medicare reimburses 100% of the physician fee schedule for PA services provided incident to a physician's service, reimbursement rates for other services provided by the PA are lower. Furthermore, these rates often vary, depending on the site of the services. For example, reimbursement for PA services performed in a nursing facility may not exceed 85% of the physician rate; in a hospital setting it may not exceed 75% of the physician rate; PA-assisted surgery reimbursement may not exceed 65% of the physician rate. Medicare services rendered by PAs are always reimbursed to the PA's employer; thus, these variables must be considered when determining the most cost-effective use of PAs.

PAs AND HEALTH SYSTEM REFORM

The roles to be assumed by PAs in the forthcoming health system reform initiatives are yet to be determined. Because PA education so closely resembles a condensed version of medical school, many of the same factors that complicate physician education and distribution are similarly experienced by the PA profession.

The argument that increasing existing PA program enrollment is less expensive than developing completely new programs must be tempered with the realities of increasing institutional competition for fixed educational resources. For example, AHCs with both a medical school and a PA program may not be able to absorb the added expense, space, and time requirements of more lecture commitments by basic science faculty, resident physicians, and staff attendings; more classroom space; and more competition for already limited teaching time on ward rounds, in the clinics, and in operating rooms. Additionally, the simultaneous demand to produce more generalist physicians may increase competition among medical schools, residency programs, and PA programs for sites for quality primary care clinical education. President Clinton's Health Security Act includes favorable provisions affecting PAs, but many questions relating to the prospective roles for PAs remain unanswered. The Health Security Act does not specify how the annual $400 million allocated for primary care education among medical schools, nursing schools, and PA programs is intended to be distributed.

Although a number of proposals suggest differing roles for midlevel providers within the context of health system reform,[1,2,4,5,46,55] the fact remains that PAs are inextricably dependent on physicians for their employment and supervision. The position stated by the American Boards of Family Practice and Internal Medicine opposing independent practice by nonphysician professionals also reflects the position of the PA profession.[56] The American Academy of Physician Assistants reaffirmed that the PA profession does not seek independent practice, direct reimbursement from third-party payers, or federal preemption of state practice acts.[57] Nevertheless, if health system reform initiatives include a greater role for PAs in the provision of health care, greater efforts must be made to improve the linkages and relationships between and among PA programs, medical schools, and generalist physician residency training programs. Introducing more medical students and

residents to the roles, functions, and capabilities of the physician-PA team in educational settings might reduce the existing degree of reluctance to "work together in well-integrated teams to enhance the quality and availability of cost-effective patient care," as called for by the American Boards of Family Practice and Internal Medicine.[56(p315)]

While the PA profession acknowledges the importance of working closely with physicians, the trend of increasing specialty practice of PAs is a topic of ongoing debate between generalist and specialty PAs.[58-60] Some generalist PAs are critical of the splintering effect of professional alignment with specialty groups, whereas some specialty PAs berate their reluctance to expand with the job market. Notwithstanding the specialty vs primary care rift within the PA profession, national health system reform measures will help determine whether PAs will continue to gain acceptance and legitimacy. Although the PA profession is faced with several obstacles to growth and expanded provider roles, success or failure in a changing environment will be measured by the profession's ability to meet the needs of the medical marketplace.

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American Academy of Physician Assistants

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MEMORANDUM

to: Patty Solis, Director of Scheduling, Office of the First Lady
from: Steve Crane, Executive Vice President, AAPA
date: May 17, 1994

Thank you again for scheduling Mrs. Clinton to address the 22nd Annual Conference of Physician Assistants.

To help her and her staff prepare for the May 25th event, I have enclosed the following information about the physician assistant (PA) profession:

Information booklet, "PArtners in Medicine"
Background sheet on the Health Security Act and PAs
Recent article about physician assistants that appeared in the Journal of the American Medical Association
Two articles about PAs
An article about the differences between PAs and nurse practitioners
An article about PAs in New Jersey, the latest state to pass legislation to allow PAs to practice (after many years of fighting legislative roadblocks set up by the state medical society and the state nursing association)
An article explaining why PAs want physician supervision, but nurse practitioners don't (a major difference between the two professions)

There are a couple of points that Mrs. Clinton may want to keep in mind when addressing the group:

- Of the more than 23,000 clinically practicing PAs, approximately 50% work in the primary care specialties -- family medicine, internal medicine, pediatrics, emergency medicine.

- Over 40% of all practicing PAs are women, even though when the profession was started in the late 1960s the first PAs were former military medics, who were men.

- According to the Department of Health and Human Services, the geographic distribution of PAs more closely matches the general population than other primary care providers. The House Budget Committee's bill report for the FY95 Budget Resolution states that "physicians assistants are the primary health care and emergency services deliverers for a high percentage of rural Americans."

- In all cases, PAs practice medicine with the supervision of licensed physicians. Most state laws allow a PA to treat patients when the physician is away from the practice and allow a PA to staff remote and rural clinics with physician located in another town.

(more)

I also though it might be helpful to address a couple of issues of professional sensitivity:

- First, the correct legal title of the profession is physician assistant -- not physician's assistant or physicians' assistant. A physician's assistant could be any individual who provides assistance to a doctor, including front office staff.

- Second, there are numerous differences between the PA and nurse practitioner education programs, certification procedures, and their scopes of practice. A major difference is in the importance PAs place on the team approach to health care by practicing with physician supervision. Talking about the two professions collectively -- as "mid-level providers" or "physician extenders" -- insinuates no philosophical or professional differences between the two. Many PAs don't work like nurses and many NPs don't work like PAs.

- Third, PAs have been compared to family nurse practitioners (FNPs) because the two professions are educated to handle patients from birth to death. It is incorrect to compare PAs to clinical nurse specialists, geriatric or pediatric nurse practitioners, nurse midwives, or in general to "advanced practice nurses" because these nurse specialists have received an education limited to specific age groups or diseases.

The program on May 25th is scheduled to go as follows:

10 a.m. Central Time -- Ann Elderkin, National President, AAPA, will call the General Session to order and discuss what AAPA has been doing in Washington, DC, and throughout the country concerning health care reform. She also will mention the visits she has made to the White House (for two Rose Garden ceremonies) and the meetings PAs and AAPA staff have had with the Health Care Task Force members and White House staff. Judith Feder was a guest speaker at a national AAPA leadership conference in Alexandria, VA, last fall.

10:10 a.m. -- Elderkin will explain the satellite feed, how the Q&A session will work and introduce Mrs. Clinton

10:15 a.m. -- (God and modern technology willing) Mrs. Clinton will address the 3,000 or so PAs attending the conference

10:30 a.m. or so -- Mrs. Clinton will conclude her remarks and ask Ann Elderkin if there are any questions from the audience

10:35 to 10:45 a.m. -- Elderkin and other PAs will read questions that have been submitted by the physician assistants attending the conference

(more)

10:45 a.m. -- Elderkin will thank Mrs. Clinton for taking the time to address the PAs and the satellite will go dark. We are considering reserving 45 minutes on the satellite (in case there are problems at the beginning or end of the transmission), so the Q&A may run a few minutes after 10:45, if that's OK.

10:50 a.m. -- Elderkin will introduce Ernesto Gomez, CEO of El Centro del Barrio, a series of health care clinics for low-income and homeless people. AAPA is presenting to Gomez a check for $5,000 to help underwrite Centro's immunization program which has served tens of thousands of low-income San Antonio children since 1980.

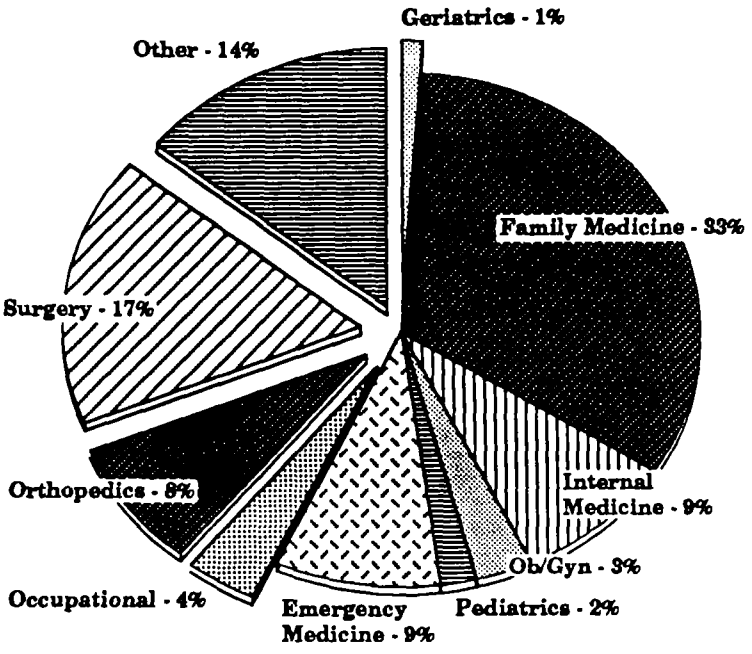
11 a.m. -- Reports from various PA leaders

11:30 a.m. -- General Session adjourns

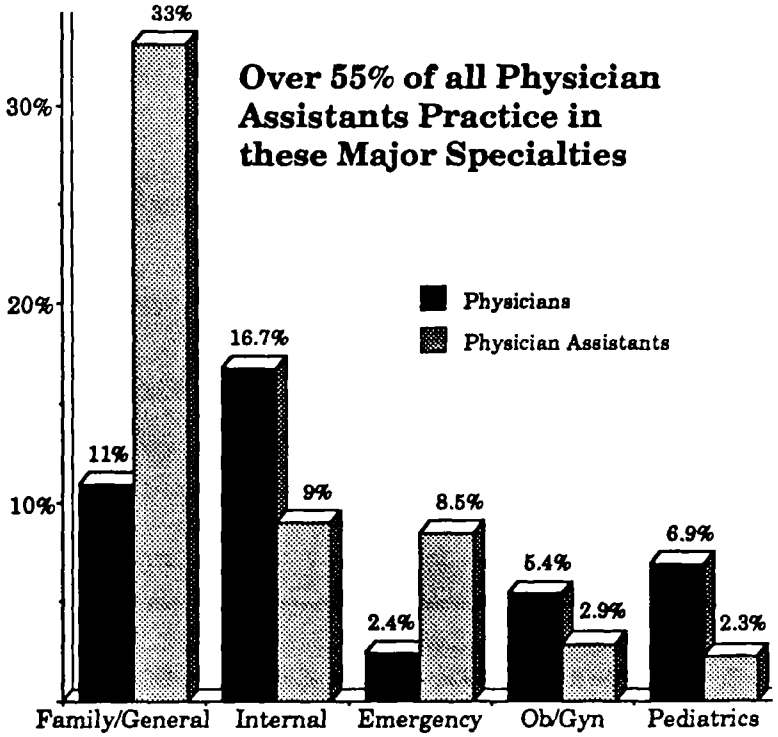
If you should have any questions concerning the arrangements for Mrs. Clinton's presentation or about the AAPA Conference in general, please call me or Nancy Hughes, AAPA Public Affairs Administrator, at the Marriott Rivercenter -- 210-223-1000 -- or at the AAPA Convention staff office -- 210-270-2973/2972.

Physician Assistants: PArtners in Medicine

- Physician Assistants (PAs) practice medicine with the supervision of licensed physicians.
- Of the 27,000 PAs who have been trained, approximately 23,500 are currently in clinical practice (87%).
- PAs are educated in a medical program and are qualified to treat approximately 80% of the patients seen by primary care physicians.
- PAs can write prescriptions in 37 states and the District of Columbia.
- Seventeen percent (17%) of all PAs practice in rural communities with fewer than 10,000 people; 34% in towns with fewer than 50,000 people.
- Seventy percent (70%) of all PAs practice in outpatient settings (clinics, HMOs, medical offices).
- PA distribution more closely matches the population than other primary care providers.
- There are 58 specially designed PA training programs located at medical colleges and universities, teaching hospitals and through the Armed Forces. The programs are accredited by the American Medical Association's Committee on Allied Health Education and Accreditation.
- A typical PA student has a bachelor's degree and over 4 years of health care experience prior to admission.



Over 50% of all Physician Assistants Provide Primary Care Services



Source: Physician Characteristics and Distribution in the U.S., 1993, American Medical Association, and 1993 Census, American Academy of Physician Assistants (AAPA). AAPA includes emergency medicine when discussing primary care use of the large number of people relying on hospital emergency rooms for basic services.

- PA education is typically 24 months in length representing approximately two-thirds that of medical students (102 compared to 153 weeks).
- Nearly all states require PAs to pass a national certifying examination administered by the National Commission on Certification of Physician Assistants (NCCPA).
- To maintain certification, all PAs must complete 100 hours of continuing medical education every two years, and take a recertification exam every six years, the only major health profession with such a requirement.
- According to the Congressional Office of Technology Assessment, "within the limits of their expertise, PAs provide care that is equivalent in quality to the care provided by physicians."
- Studies conducted by the RAND Corporation have found that PAs save as much as 20% of the costs of medical care, can perform 80% of the routine functions of a physician's practice, and are widely accepted by patients.
- Case law reveals that PAs have been involved in very few malpractice suits.
- Current national statistics indicate approximately six (6) jobs for every new PA graduate. The Department of Labor projects the number of PA jobs will grow by 44% from 1990 through 2005.

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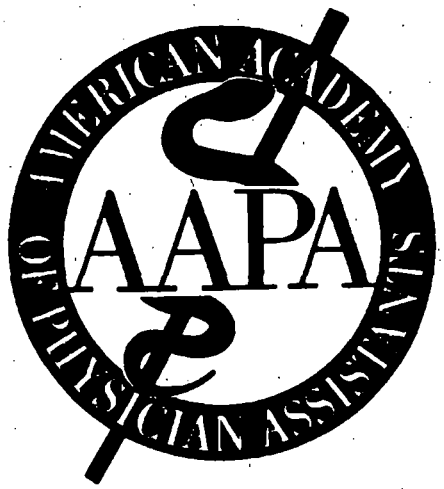
AAPA

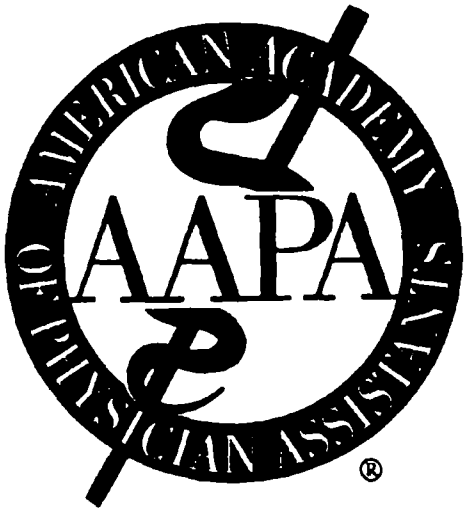
Physician Assistants:



PArtners in Medicine

Official Definition of
Physician Assistant

approved by the
American Academy of Physician Assistants (AAPA)
House of Delegates
May 1991



"**Physician assistants (PAs)** practice medicine with supervision by licensed physicians. As members of the health care team, PAs provide a broad range of medical services that would otherwise be provided by physicians.

It is the obligation of each team of Physician/PA to ensure that the physician assistant's scope of practice is identified; that delegation of medical tasks is appropriate to the physician assistant's level of competence; that the relationship of, and access to, the supervising physician is defined; and that a process of performance evaluation is established. Adequate and responsible supervision of the PA contributes to both high quality patient care and continued professional growth.

The AAPA is committed to the concept of physician assistant practice of medicine with supervision by licensed physicians."

HOD 1303-01-01
7-26-93

PHYSICIAN ASSISTANTS

BACKGROUND

Physician assistants (PAs) practice medicine with supervision of licensed physicians, providing patient care services that would otherwise be performed by physicians.

Overview

The relationship between a physician and a physician assistant (PA) is one of mutual trust and reliance. The PA's responsibilities depend on the type of practice, his or her experience, the working relationship with the physician and other health care providers, and state laws.

Educated in a medical program, PAs are qualified to perform approximately 80 percent of the duties most commonly done by primary care physicians. PAs perform physical examinations, diagnose and treat illnesses, order and interpret lab tests, suture wounds, set fractures, and preform minor surgery. In a majority of states, PAs write prescriptions.

PAs Practice Medicine

Physician assistants follow a medical model of patient care and practice medicine with supervision by licensed physicians. PAs perform a wide range of medical duties, from basic primary care to high-technology specialty procedures. Specific duties are defined by state regulation and practice setting, but include both diagnostic and therapeutic procedures. PA education also prepares physician assistants to deal with many medical emergencies. PAs often act as first or second assistants in major surgery, and provide pre- and post-operative care.

In some rural areas, where physicians are in short supply, PAs serve as the only providers of health care, conferring with their supervising physicians and other medical professionals as needed and as required by law.

Education

PAs are educated in one of 58 specially designed PA programs located at medical colleges and universities, teaching hospitals, and through the Armed Forces. Due to the close working relationship PAs have with physicians, PA education was designed to complement that of physicians.

PA programs generally require applicants to have at least two years of college education and previous experience in health care. The typical PA student in 1992 had a bachelor's degree and over 4 years of health care experience prior to admission to the PA program. PA education is usually 24 months in length and is approximately two-thirds that of medical students (102 weeks compared to 152). PAs take some of the same classes with medical students.

The first phase of PA education is in the classroom, providing students with an in-depth understanding of medical sciences. Additional subjects include differential diagnosis, medical ethics, and pharmacology. The second year is spent in clinical rotations. Each year, PA programs graduate approximately 1,700 men and women. The majority of all PA programs offer a baccalaureate degree upon completion; twelve have master's degree programs or master's options.

Practice Credentials

Nearly all states require PAs to pass a national certifying examination before they can begin practicing. The exam, open only to graduates of accredited PA programs, is given each year by the National Commission on Certification of Physician Assistants (NCCPA), an independent organization established to assure the competency of PAs.

To maintain certification, PAs must complete 100 hours of continuing medical education every two years and take a recertification exam every six years. Only those with current certification can use the credentials Physician Assistant-Certified or "PA-C."

Practice Settings

Today there are over 27,000 PAs in the United States; over 40% of all practicing PAs are women. PAs practice in almost all health care settings and every medical and surgical specialty. They also serve on the White House medical staff.

Seventeen percent of all PAs practice in rural communities with fewer than 10,000 people; a third practice in towns with fewer than 50,000 people. The majority of all PAs (57%) practice primary care, with 33% in family medicine. Seventeen percent practice in surgical specialties. Approximately 70% of all PAs practice in outpatient settings (clinics, HMOs, medical offices), and 30% practice in inpatient settings (hospitals).

Growth of the PA Profession

Demand for PA services is rapidly increasing. Current national statistics show there are approximately six jobs for every new PA graduate. The Department of Labor projects the number of physician assistant jobs will grow by 44% percent from 1990 through the year 2005.

Factors that have contributed to this growth include Medicare/Medicaid reimbursement for PA services and increased recognition of the quality of care that PAs provide.

• • • •

"Conceived during the new health practitioner movement of the 1960s, physician assistants have demonstrated their clinical effectiveness both in terms of quality of care and patient acceptance."

— Eighth Report to the President and Congress on the Status of Health Personnel in the United States

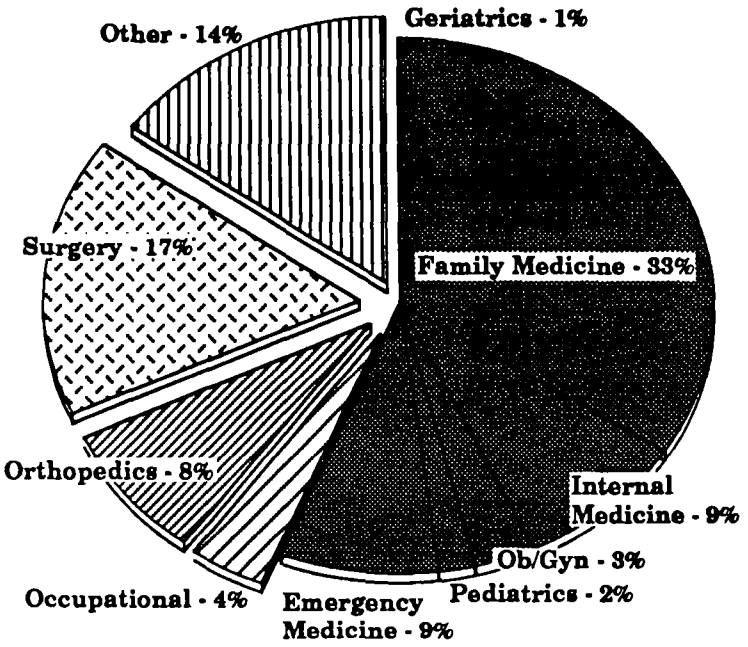
Practice Settings

Physician assistants (PAs) practice medicine with the supervision of licensed physicians, providing patients with services ranging from primary medicine to very specialized surgical care.

Currently there are over 27,000 physician assistants in the United States, nearly double the number just ten years ago. In some rural areas, where physicians are in short supply, PAs serve as the only providers of health care, conferring with their supervising physicians as needed or required by law.

While most physician assistants are in primary care settings such as a family practice, PAs also are filling roles that were not anticipated when the profession began. Some of these practice settings include nursing homes, HMOs, and occupational medicine. Many hospitals, faced with a shortage of physician residents, have discovered the value of physician assistants. PAs even serve on the White House medical staff. Physician assistants practice in nearly all medical and surgical specialties.

The PA profession has demonstrated its ability to adapt to a constantly changing health care environment. Having become an integral part of health care delivery, it is likely that PAs will continue to find, and fill, new and expanding roles in health care.



Most Physician Assistants Practice Primary Care Medicine

In 1993, 17 percent of all physician assistants worked in rural communities with fewer than 10,000 residents. Twenty percent practiced in cities with more than a million people. Fifty-seven percent of all PAs practice primary care, which AAPA defines as including family medicine, internal medicine, pediatrics, geriatrics, obstetrics and gynecology, and emergency medicine.

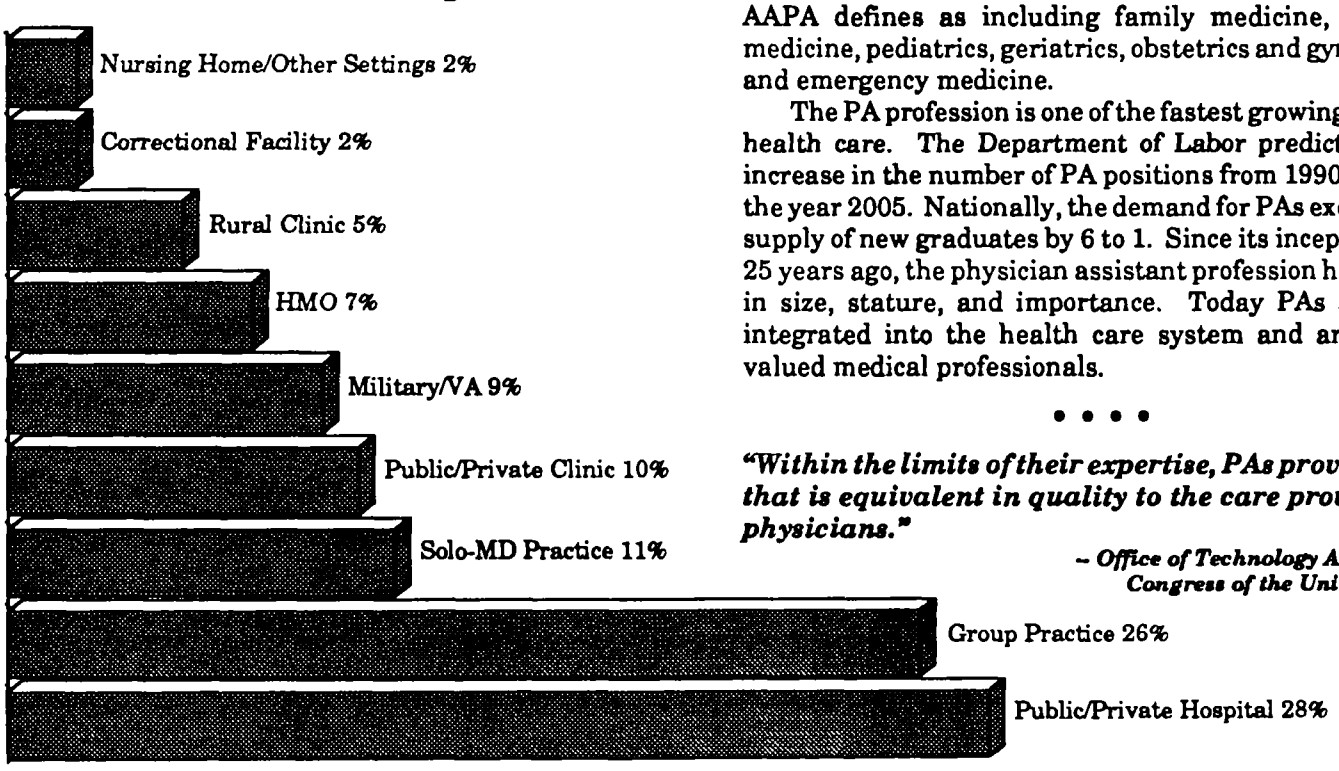
The PA profession is one of the fastest growing fields in health care. The Department of Labor predicts a 44% increase in the number of PA positions from 1990 through the year 2005. Nationally, the demand for PAs exceeds the supply of new graduates by 6 to 1. Since its inception over 25 years ago, the physician assistant profession has grown in size, stature, and importance. Today PAs are fully integrated into the health care system and are highly valued medical professionals.

• • • •

"Within the limits of their expertise, PAs provide care that is equivalent in quality to the care provided by physicians."

– Office of Technology Assessment
Congress of the United States

Approx. 70% work in outpatient settings (clinics, HMOs, medical offices) and 30% in hospitals



PHYSICIAN ASSISTANTS

EDUCATION

PA education was modeled after physician's training -- including continuing medical education to keep abreast of medical advances.

Overview

Physician assistants are trained in an intensive medical education program that usually lasts 24 months in length. The program is offered at medical schools, colleges and universities, teaching hospitals, and through the Armed Forces. Because of the close working relationship between physician assistants and physicians, PA education was modeled after physician's training and is similar in structure, albeit shorter than medical school. Physician assistants often attend the same classes with medical students.

The first year is composed of classroom instruction, with a heavy emphasis on medical sciences and related disciplines. Second-year PA students perform clinical rotations, seeing and treating patients. Some programs offer specialty training.

The Students

The typical PA student in 1992 had a bachelor's degree and over 4 years of health care experience prior to admission to a PA program. Fifteen percent of all physician assistants were nurses, 14% were emergency medical technicians, 13% were medics, and 9% were emergency room technicians before they became PAs. There is fierce competition to get into a PA program. In 1992, PA programs turned away five qualified applicants for every student accepted.

The Programs

There are 58 physician assistant programs in the United States, graduating approximately 1,700 PAs a year. Programs are accredited by the American Medical Association's Committee on Allied Health Education and Accreditation (CAHEA). Only graduates of accredited PA programs are eligible to take the national certifying examination.

National Certification

Most states require PAs to pass the national certification examination, offered by the National Commission on Certification of Physician Assistants (NCCPA). Only those successfully completing the examination may use the credentials "Physician Assistant-Certified" or "PA-C."

A PA's education does not end at graduation. In order to remain certified, physician assistants are required to complete 100 hours of continuing medical education (CME) every two years and take a recertification examination every six years. It is the only major health profession with such a requirement.

Degrees Awarded

All PA programs offer a certificate upon graduation; most offer a bachelor's degree. Twelve of the programs also have a master's degree program or master's options. More than 70% of all physician assistants have a bachelor's degree, and an additional 12% have a master's degree or higher.

• • • •

"Since the inception of the discipline in the 1960s, physician assistants have become firmly established as a provider group well suited to address problems of maldistribution of physicians and enhancing cost-effectiveness in health care."

-- Eighth Report to the President and Congress on the Status of Health Personnel in the United States

PAs IN THE US

In 1967
The physician assistant concept originated during the mid-1960s. Physicians and educators recognized there was a shortage and uneven distribution of primary care physicians. To combat these problems, the physician assistant program was developed. The first physician assistants graduated from Duke University in 1967. They were former Navy corpsmen who wanted to use their medical skills in civilian life.

Today
A majority of all PAs provide primary care, and 33% practice in towns with fewer than 50,000 residents. PA distribution more closely matches the population than other primary care providers according to the *Seventh Report on the Status of Health Personnel in the United States*, published by the U.S. Department of Health and Human Services in 1990. The report noted that, were it not for PAs, many areas would have little or no access to quality health care.

The PA Practice
Physician assistants work in all 50 states, the District of Columbia, Guam, and around the world in the military. In 1992, there were approximately 152 million patient visits to physician assistants.

The median salary range for clinically practicing physician assistants nationwide is $50,000 to $55,000, which is approximately half the average salary of a family physician.

All PAs must, by law or regulation, have a supervising physician. It is not necessary, however, for the physician and PA always to be located in the same building or even the same town. Most state laws allow the supervising physician to be away from the practice when the PA is seeing patients.

• • • •

"(Congress has) singled out programs in family medicine, general internal medicine, and general pediatrics, and training of physician assistants. . . for priority in the allocation of federal assistance because these professions will play a pivotal role in reaching the national goal of making access to primary health care more widely available and of reducing unnecessary health care costs."

--United States Congress, 1992
Public Law 102-408

Quality Care
A study by the Congressional Office of Technology Assessment concluded that "within the limits of their expertise, PAs provide care that is equivalent in quality to the care provided by physicians." Studies conducted by the Rand Corporation and others found that PAs save as much as 20% of the costs of medical care, can perform 80 percent of the routine functions of a primary care physician's practice, and are widely accepted by patients.

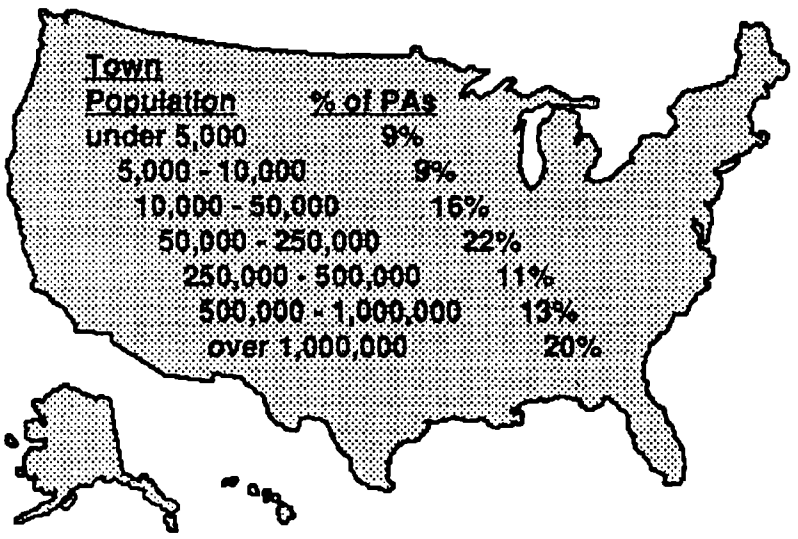
Case law reveals that physician assistants have been involved in very few malpractice cases. The majority of PAs are insured by a rider on their employer's malpractice policy; many have their own coverage.

Prescribing
A PA's practice is determined by education and experience, the supervising physician's practice, and state law. One aspect of state law is prescriptive authority.

During the last decade, the number of states granting prescriptive authority has more than doubled. Thirty-seven states, the District of Columbia, and Guam allow PAs to write prescriptions for medications.

Prescriptive practice for physician assistants is a logical outgrowth of both their role and education. PA education in pharmacotherapeutics (the study of the use of medication in the treatment of disease) is proportionally equivalent to that of physicians. The National Board of Medical Examiners determined that the PA national certification examination is a valid assessment of this knowledge. Surveys show a strong similarity between PA and physician prescribing patterns.

A state-by-state summary of the laws and regulations governing PAs is available from the American Academy of Physician Assistants.



ORGANIZATIONS

American Academy of Physician Assistants

The American Academy of Physician Assistants (AAPA) is the national professional society for PAs. Founded in 1968, the Academy has chapters in all 50 states, the District of Columbia, and Guam. There are also chapters that represent physician assistants working for the Public Health Service, the Department of Veterans Affairs, and all branches of the military.

The mission of AAPA is to "promote quality, cost effective, and accessible health care and to promote the professional and personal development of PAs." Major activities to accomplish this goal include government relations, public education, research and data collection, and professional development.

Eighty percent of all practicing physician assistants are members of AAPA. Members are graduates of accredited physician assistant programs and/or those who are nationally certified. Students at accredited programs are also eligible for membership.

The AAPA's Physician Assistants Foundation (PAF) provides funds for scholarships and research on the PA profession. In 1992, it awarded 37 scholarships totalling $87,000 to PA students and $15,000 in research grants to AAPA members.

For more information, contact:
American Academy of Physician Assistants
950 North Washington Street
Alexandria, VA 22314
(703) 836-2272

National Commission on Certification of Physician Assistants

The National Commission on Certification of Physician Assistants (NCCPA) is an independent organization established to assure the competency of physician assistants. The NCCPA was formed in 1975 by AAPA and other health professional associations in order to administer a national certifying examination to graduates of accredited PA programs. The examination and the recertification exam physician assistants are required to take every six years are designed to test the medical knowledge and clinical skills of PAs.

For more information, contact:
NCCPA
2845 Henderson Mill Road NE
Atlanta, GA 30341
(404) 493-9100.

Association of Physician Assistant Programs

The Association of Physician Assistant Programs (APAP) shares its national headquarters with AAPA. Whereas the Academy is made up of graduates and students, APAP members are the physician assistant educational programs and faculty. Founded in 1972 to help maintain the high quality of PA education, APAP's objectives are to encourage communication among the programs and to serve as a national information center on PA education.

APAP publishes the "National Directory of PA Programs," giving complete information on the names, locations, requirements, tuition, length, and degree(s) awarded for each of the accredited PA programs. The directory is available to the public for a small fee.

For more information, contact:
Association of Physician Assistant Programs
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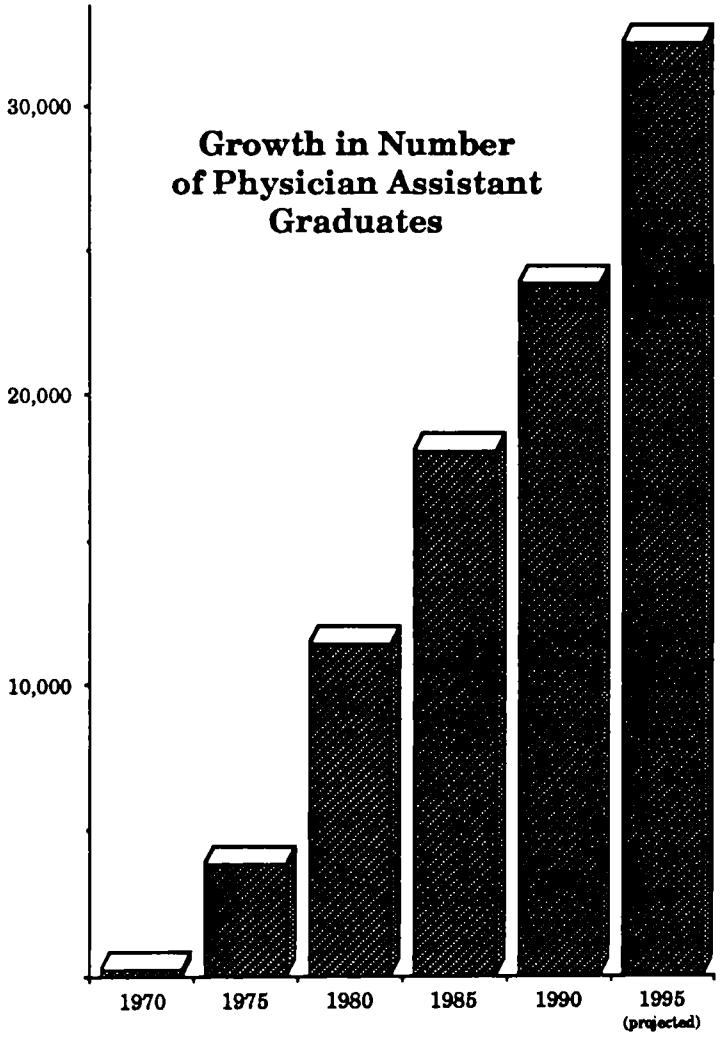

NATIONAL HEALTH CARE REFORM

President Clinton's health reform legislation, the "Health Security Act" (HR 3600, S 1757), seeks to provide quality health care to all Americans, including millions of individuals who are currently uninsured or underinsured. To accomplish this goal, the bill recognizes physician assistants (PAs) as qualified health care professionals who provide essential, cost-effective health care.

▲ Health care teams

By defining "health professional services" to include physicians and others legally authorized to provide services, the legislation recognizes that physician assistants provide quality health care that should be available to all Americans under health care reform. PAs are included in the definition of "lawful health care provider" whose services must be covered under any fee-for-service plan offered by a regional alliance.

PAs are specifically listed in the definition of health professionals who may be considered "essential community providers" eligible for certification. Health plans would be required to contract with institutions, agencies and providers certified as essential community providers in order to assure that underserved populations have access to care.

▲ Increased funding for PA education

Authorized spending has been set at $400 million to cover "primary care physician and physician assistant training," plus programs for the training of underrepresented minorities and nurses. The American Academy of Physician Assistants (AAPA) seeks specific earmarking of funds for PA educational programs.

The legislation changes the financing of graduate medical education. Rather than coming entirely from the Medicare trust fund, physician residency training would also be supported by money set aside from private health insurance premiums collected by corporate and regional alliances. In a precedent-setting move, the bill allots $200 million of these funds for graduate nurse education. The AAPA believes that PA education programs should also be eligible for GME funds, which is a steady source of financial support immune from discretionary spending caps and the annual appropriations process.

▲ Enhancement of PA practice environment

The legislation recognizes that physician assistants are essential to the delivery of primary care and preventive services, particularly if all Americans are to have access to quality health care. It includes language encouraging and supporting full utilization of the "professional education and clinical skills of advanced practice nurses and physician assistants."

Within the Department of Health and Human Services, programs are authorized to encourage the adoption of model professional practice statutes for PAs and to support the removal of inappropriate barriers to practice. The AAPA seeks the addition of language directing the Secretary of HHS to consult with the appropriate professional society on the issue of a model law.

The Health Security Act does not provide for a federal preemption of restrictive state practice acts. Rather, it declares that "No state may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals." The AAPA supports the removal of unnecessary practice restrictions, but does not believe the federal government should override state laws.

▲ Increased access for Medicare beneficiaries

The legislation amends existing law and extends Medicare coverage for outpatient physician services provided by PAs from rural Health Professional Shortage Areas to all geographic areas. Reimbursement would be paid to the PA's employer at 85 percent of the physician's fee. This provision is essential and must be included in any health care reform legislation enacted by Congress.

▲ **Support for providers in underserved areas**

The bill increases funding for the National Health Service Corps ($50 million in FY95, $100 million in FY96, and $200 million for each of fiscal years 1997 to 2000). The AAPA recommends replacing the bill's proposed requirement that 20 percent of all NHSC participants be nurses with language doubling the current 10 percent set-aside of scholarship and loan repayment awards for PAs, nurse practitioners and nurse midwives.

The Health Security Act contains a $500 per month personal tax credit for primary care physician assistants practicing full-time in Health Professional Shortage Areas. The AAPA recommends modification of the recapture provisions for PAs unable to complete the 60-month mandatory service period and extension of this credit to PAs working in underserved areas prior to 1995. The AAPA recommends the extension of the tax credit beyond five years.

The AAPA also recommends that Medicare bonus payments, currently available only to physicians, be authorized for PAs working in underserved areas.

▲ **Miscellaneous provisions**

The legislation authorizes $200 million for skill enhancement and retraining programs to be administered by the Department of Labor. These include retraining health care workers for more advanced positions as technicians, nurses, and physician assistants.

The Health Security Act would establish a National Council on Graduate Medical Education, a National Council on Graduate Nurse Education, and a National Institute for Health Care Workforce Development. The AAPA recommends that Congress consider consolidation of these functions to avoid unnecessary bureaucracy and to achieve more effective workforce planning and administration.

AAPA National Health Reform Policy

The American Academy of Physician Assistants believes that a national health care program should provide basic health care services to all residents and that the scope of such services should be determined by public policy and be based on considerations such as medical effectiveness. Health care services should be provided by qualified persons who practice a team approach to care. Patients should retain a choice of providers and be satisfied with the quality of care offered by the providers and the health care system.

In addition, AAPA believes that the structure of a national health care program should be determined by the federal government, and administered by the states under national guidelines. Financing mechanisms should be fair, equitable, and include cost controls.

The AAPA advocates a national health care program based on these principles because the existing fragmented system inhibits access and is inherently inflationary. Only a well-managed national health care program can guarantee universal access and moderate health care expenditures.

AAPA Position on the "Health Security Act"

Therefore, to the degree that the President's "Health Security Act" meets these principles, the American Academy of Physician Assistants can support the proposal. The AAPA applauds the bill's focus on universal access and comprehensive primary and preventive care services; its emphasis on a team approach to health care delivery; its attention to research on effective medical procedures; and its preservation of the patient's right to choose his or her health care provider.

5/94

The American Academy of Physician Assistants ▲ 950 N Washington St ▲ Alexandria, VA 22314

Special Communication

Physician Assistants and Health System Reform

Clinical Capabilities, Practice Activities, and Potential Roles

P. Eugene Jones, PhD, PA-C, James F. Cawley, MPH, PA-C

NATIONAL efforts to reform the health care system will likely result in changes in the roles and responsibilities, practice combinations, and distribution of health professionals, including midlevel providers such as physician assistants (PAs), nurse practitioners (NPs), and certified nurse-midwives. Although recent studies have addressed differing scenarios of the projected roles of midlevel providers,[1-6] implementation of initiatives that involve PAs may be influenced by an overall shortage of PAs, existing barriers to PA practice, and the need for commitment to physician-dependent practice relationships in a team-oriented health care delivery system. This article reviews the history, academic preparation, clinical capabilities, distribution, and practice activities of PAs and discusses the potential roles of PAs in the changing health system environment.

The origin of the PA can be traced to the new health practitioner movement of the 1960s, during which the PA concept emerged from a combination of events. As experienced hospital corpsmen and combat medics returned from service in Vietnam, there were no civilian job equivalents or suitable health career pathways in the United States. Simultaneously, a new health care provider model proposed in 1961[6] resulted in the development of the first PA program at Duke University School of Medicine. According to this concept, PAs "would be trained to assist the doctor . . . in such a way as to facilitate better utilization of available physicians and nurses."[7] These circumstances eventually resulted in the matriculation of substantial numbers of military veterans into newly developing PA programs. Subsequently, more PA programs were developed to train providers who would (1) augment the capabilities of primary care physicians by increasing access to basic medical care services, (2) fill service gaps resulting from geographic and specialty maldistribution of physicians, and (3) help control health care costs.[8,9]

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PA EDUCATION

By 1993, there were 58 accredited PA programs in 29 states and the District of Columbia and 27 403 program graduates.[10,11] With the exception of a few hospital-, military-, and community college–based programs, the majority of PA programs are affiliated with academic health centers (AHCs), medical schools, or 4-year colleges and universities, 26% of which are classified as category I research universities by the Carnegie Foundation for the Advancement of Teaching.[12] Thirty-five PA programs (60%) offer a baccalaureate degree or degree option, 12 (21%) offer master's degrees, and the remainder grant an associate degree or a certificate of completion.

Essentials for PA Education

The "Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician" were initially adopted in 1971 by the American Medical Association in collaboration with the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Society of Internal Medicine.[13] Following the organization of the Committee on Allied Health Education and Accreditation in 1977, the Essentials were revised in 1978, 1985, and 1990. The Essentials establish minimum standards of quality to which accredited programs are held accountable. After the Essentials initially were adopted, federal funding acts supported the expansion of PA educational programs' emphasis on a primary care orientation for preparing generalist PAs.[14]

According to the current Essentials of the Committee on Allied Health Education and Accreditation, PAs are "academically and clinically prepared to provide health care services with the direction and responsible supervision of a doctor of medicine or osteopathy. The functions of the physician assistant include performing diagnostic, therapeutic, preventive and health maintenance services in any setting in which the physician renders care, in order to allow more effective and focused application of the physician's particular knowledge and skills."[15(p6)]

Clinical services performed by PAs are described by the Essentials in the following six categories[15(pp6-7)]: (1) *evaluation*—initially approaching a patient of any age group in any setting to elicit a detailed and accurate history, perform an appropriate physical examination, delineate problems, and record and present the data; (2) *monitoring*—assisting the physician in conducting rounds in acute and long-term inpatient care settings, developing and implementing patient management plans, recording progress notes, and assisting in the provision of continuity of care in office-based and other ambulatory care settings; (3) *diagnostics*—performing and/or interpreting, at least to the point of recognizing deviations from the norm, common laboratory, radiological, cardiographic, and other routine diagnostic procedures used to identify pathophysiological processes; (4) *therapeutics*—performing routine procedures such as injections, immunizations, suturing and wound care, management of simple conditions produced by infection or trauma, and assistance in the management of more complex illness and injury, which may include assisting surgeons in the conduct of operations and taking initiative in performing evaluation and therapeutic procedures in response to life-threatening situations; (5) *counseling*—instruction

and counseling of patients regarding compliance with prescribed therapeutic regimens, normal growth and development, family planning, emotional problems of daily living, and health maintenance; and (6) *referral*—facilitating the referral of patients to community health and social service agencies when appropriate.

Curriculum Content

Prior to matriculation, the typical PA program requires the student to have completed the equivalent of 2 years of undergraduate-level biological, social, and behavioral science prerequisites. The first 9 to 12 months of PA education are devoted to preclinical didactic studies and include courses in anatomy, physiology, microbiology, pharmacology, psychology, clinical medicine, physical diagnosis, preventive medicine, and clinical laboratory procedures.[16] Courses in the basic medical sciences account for 77% of the didactic component of PA education, with the remainder devoted to behavioral and social sciences. Educational programs for PAs average more than 1004 contact hours of didactic instruction.[17] These courses are typically followed by 9 to 15 months of physician-supervised clinical education in both inpatient and outpatient settings in urban, inner-city, and rural communities.

In some AHCs, didactic PA education and medical student education is conducted with shared classes and resources, and PA students typically are educated in a clinical setting by residents, attending physicians, and graduate PAs. Most programs include supervised clinical educational experiences for PA students in rural or medically underserved areas. In addition, several hospital- and university-based postgraduate courses of instruction exist in medical and surgical specialties such as neonatology, pediatrics, emergency medicine, occupational medicine, and surgery.

Primary Care Deployment Models

A number of PA programs have developed specialized curricula designed to promote primary care practice in underserved communities, including content on substance abuse education for health professionals, geriatrics, mental health, health care for the homeless, women's health initiatives, environmental/occupational medicine, medical Spanish, and a general orientation toward prevention in the delivery of health care.[14] Many programs have successfully placed graduates in chronically underserved areas via decentralized educational projects.[18,19] For example, participants in the Stanford University Primary Care Associate Program were twice as likely to be employed in rural communities (<10 000 population) as nonparticipants (33% vs 16%).[20] A 1992 survey of participants in the University of Nebraska PA Program's Rural Health Opportunities Project revealed a similar graduate employment rate (33.4%) in communities with fewer than 10 000 population.[21] More recently, a satellite educational project developed by the University of Washington–MEDEX Northwest Physician Assistant Program provides on-site didactic and clinical education for rural and Native Alaskan matriculants in Sitka, Alaska, and additional MEDEX Northwest projects link the University of Nevada and Boise State University with area health education centers for rural PA deployment.

Several PA programs have developed master's degree majors for PAs who will serve underserved populations and areas of special need. Graduate PA programs in rural health are offered at Alderson-Broaddus College in Philippi, WVa, and the University of Nebraska–Omaha. Public health education is offered in combined PA/MPH programs at The George Washington University, Washington, DC, and the University of Oklahoma in Oklahoma City, and a combined PA/MS degree in preventive medicine is offered at the University of Iowa in Iowa City.

AHC-Affiliated PA Programs

Of the 58 accredited primary care PA programs, 27 (47%) are sponsored by AHCs. Twice as many AHC-based PA programs receive federal grant support as non–AHC-based programs, and at a 12% greater dollar amount than non–AHC-based PA programs. Because federal PA training grants are tied to demonstrated success in primary care education and graduate placement in health professional shortage areas, it follows that AHC-sponsored PA students spend more time in primary care–based clinical education and are employed in primary care settings at a greater rate than non–AHC-sponsored students.[22] Consequently, AHC-based PA programs may be better positioned than non–AHC-based programs to contribute to the goals of the Health of the Public Program[23] by providing interdisciplinary didactic and clinical education in population-based competencies, by continuing emphasis on health promotion and disease prevention activities,[24] and through PA faculty service and student rotations that augment community access to health care services.

Funding Sources

In 1993, 33 PA programs received a total of $6.65 million in federal training support under Title VII authorization through the Health Resources and Services Administration Grants Program for Physician Assistants of the Public Health Service, administered by the Division of Medicine. In the same year, the mean PA program budget was $457 000 and the average Title VII grant award was $143 000, which accounted for 28% of program operating costs.[22] Fiscal year 1995 authorization is $9 million.

Title VII funding preferences and priorities for PA program education grants have traditionally emphasized primary care education and deployment, affiliation with graduate programs in family medicine, and strategies for increased enrollment and retention of underrepresented minorities. Funding preferences and priorities for the fiscal year 1994 application cycle address medically underserved community practice, generalist specialty practice, and increased enrollment of minorities or low-income applicants.

From the inception of PA educational programs, internal support from sponsoring institutions has increased steadily while external (primarily federal) support has remained at about one third of total program revenues. This trend reflects increasing self-sufficiency on the part of PA programs, because the level of federal support during the past 7 years has remained relatively constant.

The overall cost of PA education remains relatively low. The average total cost for educating a PA student is approximately $8029 per year at AHC-sponsored programs and $7546 per year at non–AHC-sponsored programs.[22]

Response to Federal Initiatives

Educational programs for PAs have responded to federal grant initiatives by specifically targeting curriculum content toward primary care for medically needy populations. This includes special focus on topics such as the acquired immunodeficiency syndrome, substance abuse, adolescent pregnancy, childhood immunizations, risks of cancer and heart disease, and reduction of infant mortality. More than half of all PA programs have developed specific educational content to address the health and medical problems of inner-city populations. Most PA programs have developed strong linkages with area health education centers, community education centers, rural health clinics, community/migrant health centers, and other primary health care agencies and settings. Fellowships for PAs in migrant health centers are jointly sponsored by the Health Resources and Service Administration, National Rural Health Association, American Academy of Physician Assistants, and Association of Physician Assistant

Table 1.—Physician Assistant Specialty Distribution, by Percentage, 1974 Through 1993*

Specialty	1974 N=939	1978 N=3416	1981 N=4312	1984 N=6552	1987 N=10 692	1993 N=14 746
Family practice	43.6	52.0	49.1	42.5	38.7	34.5
General internal medicine	20.0	12.0	8.9	9.2	9.5	9.5
General pediatrics	6.2	3.3	3.4	4.1	4.0	2.3
General surgery	12.1	5.5	4.6	5.1	8.8	6.4
Surgical specialties	6.8	6.2	7.7	12.5	13.8	20.6
Medical specialties	3.9	6.3	2.7	4.8	7.1	6.0
Emergency medicine	1.3	4.9	4.5	6.4	6.5	8.2
Occupational medicine	1.8	2.7	3.1	4.1	4.1	3.1
Other†	4.3	7.1	16.0	11.3	7.5	9.4

*Sources of data are references 10 and 29.
†Other includes pediatric specialties, physical and rehabilitation medicine, psychiatry, public health, and radiology (all <1%); 3.3% were not identified.

Programs to promote PA practice in migrant health settings.

Faculty

Educational programs for PAs experience difficulty in identifying, recruiting, educating, and retaining sufficient numbers of qualified faculty members. The combination of an enlarging applicant pool, pressure to increase the number of PAs trained per program, and an increasing number of clinical employment opportunities has resulted in an "academic hourglass" effect, further complicated by an already insufficient supply of experienced PA educators. Because of the disparity between academic and clinical income potential, faculty positions designed as joint teaching–practicing clinician positions are commonplace means of income supplementation. Sixty-nine percent of PA faculty are concurrently engaged in part-time clinical practice, averaging 10 hours per week, earning an average wage of $26.29 per hour.[25]

As with most professional schools, no formal pathway exists for PA-specific educator training. Clinically experienced PAs are typically self-referred or recruited into PA education, usually with little or no formal preparation in the foundations of educational theory and practice.[26] Of the PA program personnel identified as faculty in 1993, 13.6% held doctorate degrees, 35.2% held master's degrees, and 49.2% held bachelor's degrees. The remaining 2% held associate degrees (1%) or were not reported.[22]

Applicants and Students

As with other health professions, interest in PA education continues to increase. In 1988, PA programs averaged 86.1 applicants for 25.9 seats. By 1992, the number of applications increased to an average of 203 per PA program (an increase of 136%), and the number of enrolled students increased to 35 per program.[22] Preliminary reports of the 1994 applicant pool indicate that many programs have nearly twice the number of applicants compared with 1993.

The typical student entering PA training is a 26-year-old white woman with a 3.1 grade point average and more than 4 years of previous health care experience. Since 1984, women have constituted more than 60% of enrolled PA students, and since 1987, ethnic minorities have represented about 20% of matriculants. Most students enter PA education with either a baccalaureate degree or substantial course work in the premedical sciences. An increasing number of matriculants (7.2% in 1993) hold master's or doctoral degrees.[25]

CLINICAL SERVICES AND SETTINGS

At present, approximately 23 350 PAs are employed in clinical practice in 49 states and the District of Columbia. Trends in practice patterns of recent PA program graduates reveal increased numbers in inpatient and institutionally based settings and, until recently, fewer entering primary care practice. In 1993, 44% of PAs were employed in primary care settings, defined as family or general practice, general internal medicine, or general pediatrics (Table 1). The largest share, 34.5%, worked in family or general practice.[10] The 28% of PAs employed by hospitals included more than 6% in outpatient clinic practice (Table 2).

The distribution of PA practice settings is geographically disproportionate. Fewer recent graduates of PA programs in eastern states entered primary care practice settings (54.4%) compared with graduates in central (73.8%) and western states (70%). Seventeen percent of PAs practice in communities with a population of fewer than 10 000, and 34% practice in communities with a population of fewer than 50 000. More than 86% of all graduate PAs remain in full-time clinical practice.[10]

Changing Profiles

The demographic profile of PAs has changed markedly since the profession's inception. Although it remains a relatively young profession (the mean age of PAs is 40 years), the proportion of women PAs is now more than 42%, increasing from less than 10% in the 1970s. Almost 10% of PAs are ethnic minorities, and more than 32% are military veterans.[10]

Nearly 35% of all PAs are employed in private physicians' practices (either solo or group) and 28.5% practice in hospitals, with other PAs distributed in health care settings such as managed care organizations (7.3%), the military (4.6%), rural clinics (4.7%), Department of Veterans Affairs facilities (4.2%), and correctional facilities (2.5%). The remainder practice in nursing homes, inner-city clinics, and other clinical settings. Notable employment trends reveal fewer PAs in family medicine and more PAs in medical and surgical subspecialties (Table 1). The proportion of PAs employed in hospital settings reflects a relatively stable distribution over the past decade (Table 2).[27]

While PA practice settings continue to diversify, the largest percentage remain employed in primary care. A number of the same socioeconomic factors that discourage physicians from practicing primary care may influence PA employment decisions as well.[8] Despite the fact that most PAs are in primary care practice, it is clear that specialty and institutional employers are competing for PA services, and the patterns of diversification and specialization of PA employment further complicate an imbalanced educational supply and occupational demand mismatch.[28]

Income

As demand for PA services has grown, salaries in both primary care and specialty settings have increased accordingly. In 1993, the mean annual salary for PAs in all practice settings and specialties was $53 500, excluding fringe benefits and part-time income. Those employed in surgical specialties earned an average of $60 800 per year.[29] In a 1991 study of 6228 PAs, with the exception of those in practice less than 1 year, salaries among men were approximately $5000 greater than among women, even after controlling for clinical specialty, number of years in practice, number of patient visits per week, and number of hours worked per week.[30]

PA Productivity and Cost-effectiveness

The potential roles to be assumed by PAs in health system reform will likely correlate with their productivity and cost-effectiveness. Outcomes will differ from practice to practice, depending on variables such as the specialty, setting, and barriers to employment. The productivity and cost-effectiveness of PAs have been described and measured by the time spent per visit, average num-

Table 2.—Trends in Physician Assistant Practice Settings, by Percentage, 1981 Through 1993*

Practice Setting	1981 N=4312	1984 N=6552	1987 N=3309	1993 N=14 746
Private office†	35.8	34.5	33.2	34.6
Hospital	29.5	31.3	28.6	28.5
Ambulatory clinic‡	24.9	17.7	17.0	20.4
Health maintenance organization	NA§	NA	6.9	7.3
Military	9.4	7.3	7.6	4.6
Other‖	0.4	9.2	6.7	4.6

*Sources of data are references 10 and 29. Data for 1987 are from reference 29 only.
†Either solo or group practice.
‡Includes community-based public, privately sponsored, inner-city, substance abuse, student health, correctional medicine, and rural health clinics.
§NA indicates not available.
‖Other includes Veterans Affairs (4.2%) and nursing homes (0.4%).

ber of visits per unit of time, number of office visits or procedures, charges generated, overhead reduction, and increased physician activity.[4,31-34] In 1993, outpatient-based PAs saw an average of 22.1 patients per day, compared with an average of 15.7 patients per day for inpatient-based PAs.[10] Although many variables are influenced by the actual practice setting, the evidence suggests that physicians can increase their practices' output by employing PAs, and PAs "are capable of carrying substantial proportions of the workloads of primary-care physicians."[4(p43)]

Quality of Care

Indicators of the quality of care provided by PAs have been measured by comparing processes and outcomes between physician- and PA-provided care with regard to functions performed by both. Within their areas of competence, PAs have been shown to provide care indistinguishable in quality from care provided by physicians.[4,35] Indirect indicators of quality, such as physician acceptance and patient satisfaction, have also been favorable.[36,37] However, existing quality-of-care studies of midlevel providers have recently been criticized for being dated and methodologically flawed.[38] The need for current data derived by rigorous health services research methods is clearly indicated.

Responsibility and Accountability

State legislation governing PA scope of practice exempts PAs from the unlicensed practice of medicine with the stipulation that they function under the supervision of a licensed physician. Legally, the physician-PA relationship is one of *respondeat superior*, wherein the physician is liable for exercising care in the selection and supervision of the PA, has the right of control of the assistant, and is "liable for the negligent acts of employees performed within the scope of the employment relationship."[39(p102)] Although the supervising physician retains "vicarious liability," PA practice accountability has progressed from a delegatory model achieved by amending medical practice acts to a regulatory/authority model, wherein state licensing boards are authorized to govern PA practice. These amendments and exemptions establish PAs as the agents of their supervising physicians, and PAs maintain direct liability for the services they render to patients. Supervising physicians, who define the standard to which PA services are held, are vicariously liable for services performed by their PAs under the doctrine of *respondeat superior*.

COMPARING PAs AND NURSE PRACTITIONERS

A recent study estimated there are 27 226 NPs, distinguished from other registered nurses by state boards of nursing data. Exact numbers are unknown because of overlapping NP titles, specialty practice roles, and differing state requirements for NP education and accreditation.[40] The majority of NP practice settings were reported in family and adult medicine, pediatrics, and women's health.

A 1993 study of 51 midlevel provider educational programs (22 NP, 20 PA, two combined PA/NP, and seven certified nurse-midwife programs) compared legal, professional, and political differences between PAs and NPs.[19] Although varying degrees of differences and similarities were reported between PA and NP educational programs, the main distinction in their orientation to health care is that NP programs are typically set within schools of nursing, with education provided in the nursing model. In contrast, PA programs are typically affiliated with medical schools, with education provided primarily by physicians. However, these differences are less distinct in some regards; physicians contribute to NP education, and NP and PA educators often "cross-teach" between and among programs. In California, two programs jointly train PAs and NPs within the same department, and approximately one third of California PAs are also nurses.[41]

Although PA and NP clinical roles within managed care organizations and ambulatory settings are often regarded as interchangeable, reports comparing PA and NP productivity have differed in their findings. One study reported that both groups saw similar numbers of ambulatory adult patients in a large managed care setting,[42] whereas another reported that PAs had more direct patient encounters and generated twice the gross dollar income per day when compared with NPs.[43] These differences were not fully accounted for but were partially attributed to the tendency for NPs to spend more time providing counseling services. Debate continues on the practice productivity advantages and disadvantages between PAs and NPs, but researchers appear to agree that the potential for increased productivity for both groups is greater in larger practices and managed care settings. Nevertheless, both PAs and NPs directly reflect physician levels of task delegation in their clinical productivity.[4]

The practice of PAs is regulated under states' Medical Practice Act provisions and is based on physician supervision and task delegation, whereas NPs practice under nursing licensure provisions of Nurse Practice Acts. Research evidence clearly shows that the tasks described and roles performed by PAs and NPs are more similar than different in many ambulatory practice settings, but two major issues serve to differentiate the professions: (1) their general orientation to health care and (2) the desire for independent (NPs) vs dependent (PAs) practice relationships with physicians.[44] This divergence may have important implications for both professions if health reform measures include greater roles for PAs and NPs in private practices, managed care systems, and institutional settings.

POTENTIAL ROLES OF PAs

Under federal aegis, increasing attention is now focused on a generalist-provider–oriented system of health care. However, the projected roles of PAs in such a system are still undetermined. According to the US Public Health Service, PAs "have become firmly established as a provider group well suited to address problems of maldistribution of physicians and enhancing cost-effectiveness of care," and increasing demand for PA services was attributed to the revitalization of the National Health Service Corps, liberalization of authority to prescribe, and the increased use of PAs in hospital-based settings as a means of cost-control.[45(p7)] What remains to be seen is the level of demand and the clinical practice settings in which PA services will be required.

The federal government reinforces the

primary care focus of PA program curricula by awarding Title VII training grants for programs demonstrating a record of successfully meeting primary care–oriented funding preferences and priorities. However, the possible redistribution of medical and surgical subspecialty residency educational positions recently recommended to Congress by the Physician Payment Review Commission (PPRC) and the Council on Graduate Medical Education may result in increased use of PAs and other midlevel providers in inpatient specialty settings. This may occur as a result of a PPRC-projected loss of 11 000 residency slots.[46] Among the PPRC recommendations was a call for increased funding for specialty-trained PAs and other midlevel providers to maintain levels of inpatient care previously provided by residents. Another report reinforced this proposal, suggesting a need to determine "the extent to which nurse practitioners and physician assistants can substitute for and enhance both generalists and specialists. . . ."[2(p1073)]

The PA profession realizes increasing opportunities in medical and surgical specialty practice, and the 77% of PA programs that are federally funded are obligated to maintain generalist-based curricula. Although many newly graduated entry-level PAs are initially employed in specialty settings, the more plausible solution to the potential demand for more specialty-trained PAs may be to increase the number of postgraduate and master's level specialty programs. The projected number of PAs who will graduate in 1994 is 2100. If Title VII educational grants increase as projected, approximately 3300 PAs would graduate in 1996, followed by 3800 graduates in 1997. The annual PA graduation rate would increase to approximately 4000 by the year 2000, resulting in a total of approximately 41 000 PAs in practice. This number includes the assumption of a 1% to 3% attrition rate and the remaining years of expected practice, given the mean PA age of 40 years.[47] However, the distribution of PA practice settings will likely be influenced by a combination of market forces and reform initiatives.

Hospital-Based PAs

As the proportion of PAs working in primary care practices declined during the 1980s, the proportion of hospital-based PAs remained relatively stable. However, the distribution of PAs within hospital settings has changed, from fewer PAs in hospital-based outpatient clinics to more PAs in inpatient service roles. While PAs employed in the surgical subspecialties increased from 7.7% in 1981 to 21.7% in 1993, PAs employed in hospital settings ranged between 28% and 31.3% (Table 2). By 1992, 48.6% of practicing PAs indicated at least some inpatient care responsibility.[48] In many teaching hospitals, a combination of residency program retrenching, curtailed availability of international medical graduates, and cost-control measures has contributed to expanded inpatient roles for PAs. As a result, PA use in inpatient care roles in a wide variety of hospital settings has become commonplace.

A recent study of 1690 hospital-based PAs revealed that 45% held the job title of or were identified as "house officers." More than 90% had formal medical staff privileges and were credentialed under hospital bylaws. Their practice distribution included 19.4% in surgical subspecialties, 18.6% in medical specialties, 14.8% in emergency medicine, and 9.5% in general surgery.[48] Although the study was inconclusive in determining the levels of resident physician/house officer substitution performed by hospital-based PAs, the authors recognized the need for additional PA education in liability protection and risk management and additional research in levels of responsibility, outcomes, and privileging issues.

PAs and Managed Care

The increasing management by for-profit corporations and the economies of scale realized by capitated managed care organizations require careful cost-benefit considerations in provider ratio and distribution decisions. However, many variables contribute to differing levels of PA role and distribution settings within managed care organizations. Although managed care PAs assume a range of duties in a variety of clinical settings, it appears that physician attitudes toward PAs play a major role in staffing decisions; thus, midlevel provider distribution among similar settings within the same organization can differ significantly.[43]

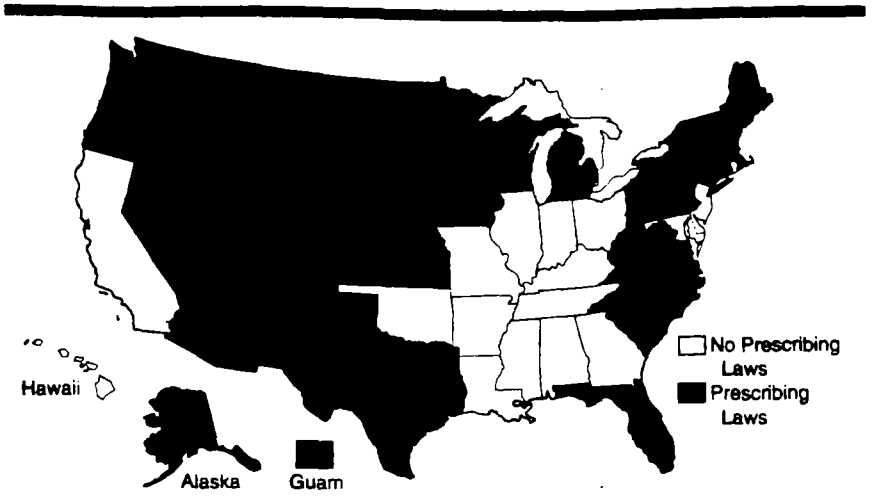
In ambulatory managed care settings, PAs have been shown to be capable of handling approximately 80% of the health care services required to manage patient problems at physician-equivalent levels of patient satisfaction and quality of care.[49] This finding is consistent with observations made in rural private practices, urban ambulatory care clinics, and geriatric settings.[19] In a large group-model health maintenance organization, physicians and PAs were found to see a similar number and type of adult ambulatory patients on an hourly, daily, and annual basis, and PAs were employed at approximately 50% of physician costs.[49] However, additional and more recent data are needed to determine frequency and appropriateness of PA consultation and referral activities, prescribing habits, rate and frequency of patient return visits, comparable degrees and mix of patient difficulty, and the amount of "nonbillable" physician time spent in consultation and supervision of PAs within such settings. In the absence of these data, the evidence indicates that, in organized ambulatory care practices where team approaches and structured division of staffing are present, PA clinical productivity compares favorably with that of physicians.[49]

BARRIERS TO PA PRACTICE

In 1993, PAs were recognized as health care providers by the medical licensing boards of 49 states and the District of Columbia; Mississippi is the only state that does not recognize PAs. State legislative and regulatory agencies maintain control over the patterns of utilization of PAs through their authority to license and regulate the profession. Barriers to enhancing the use of nonphysician health care providers were recently reported as professional territorialism, licensure restrictions, educational isolation, physician resistance, and institutional inertia.[3] These barriers vary geographically, as well as between and among differing nonphysician provider professions. As a means of reducing these barriers and encouraging change in health care delivery, the Office of the Inspector General called for an increased emphasis on supervisory and management skills in curricula for health care educational institutions and the development of cooperative practice models among different health care professions. A combination of population demographics and regulatory and reimbursement policies appears to have the greatest influence on PA practice favorability, particularly in states with disproportionate rural or medically underserved communities. However, current data that more clearly define regional and national barriers to PA practice are needed if health system reform plans include an increased use of PAs.

PA Supervision

The physician-PA employment relationship has been and is intended to remain a dependent one. The fundamental elements of PA practice (use of a referral system, frequent consultation, and periodic review) are said to be synonymous with a well-designed health system.[50] The PA's ability to consult with and refer to the supervising physician is the key factor to a successful workplace relationship, and studies suggest that the task delegation and supervision behaviors of the physician have the greatest influence on PA clinical productivity.[51] Geographic practice isolation in rural and frontier



Physician assistant prescribing authority, 1993.

settings may by necessity result in varying degrees of off-site physician supervision of the PA, and this physical separation requires a certain amount of autonomous judgment, particularly when the PA is the only available on-site provider. Regulatory reluctance to support such relationships in satellite and remote settings restricts the ability of PAs to provide needed services that might otherwise be unavailable.

Prescriptive Authority

A total of 35 states, the District of Columbia, and Guam authorize PAs to prescribe medications, but a nucleus of states do not. The cluster of 12 states (Figure) represent approximately 37% of the total US rural health professional shortage areas.[52] Although prescriptive authority varies from state to state and ranges from using protocol-based formularies for noncontrolled substances to prescribing controlled substances, PA prescribing must be done with the agreement and supervision of the physician. Patterns observed in rural PA practice in Texas reveal an example of the potential effect of prescriptive authority to increase the capabilities of PAs to improve access to care. Prior to PA prescriptive legislation passed in 1991, Texas had 26 rural health clinics. By November 1992, the number had nearly quadrupled, increasing to 99. During the same period, the percentage of Texas PAs practicing in rural areas tripled, from 5% to 15%.[53,54]

Reimbursement Issues

Variation in state laws regarding compensation for PA-provided services has also influenced PA deployment. For example, successful implementation of the Rural Health Clinic Services Act (Public Law 95-210), which provides for criteria-specific Medicare and Medicaid reimbursement for PA services, is hindered in some states by variations in the scope of their practice laws governing PAs. The practice of PAs is also complicated by state-by-state Medicaid reimbursement policies that remain inconsistent. The services of PAs are governed by the "incident to" provision, which allows for reimbursement at the physician fee level for office or clinic services provided by the physician's staff that are considered integral, although incidental, to the physician's services. The physician must be present when the PA-performed services are delivered, and the PA's services are billed and paid for as if the physician had performed them. Differing states' interpretations of the incident to physician service clause of Medicare and its carriers confuse PA employers regarding reimbursement for services provided by PAs, especially where on-site supervision is not always required, and where PAs are hired by practices for the specific purpose of extending medical services to rural and underserved communities.

Although Medicare reimburses 100% of the physician fee schedule for PA services provided incident to a physician's service, reimbursement rates for other services provided by the PA are lower. Furthermore, these rates often vary, depending on the site of the services. For example, reimbursement for PA services performed in a nursing facility may not exceed 85% of the physician rate; in a hospital setting it may not exceed 75% of the physician rate; PA-assisted surgery reimbursement may not exceed 65% of the physician rate. Medicare services rendered by PAs are always reimbursed to the PA's employer; thus, these variables must be considered when determining the most cost-effective use of PAs.

PAs AND HEALTH SYSTEM REFORM

The roles to be assumed by PAs in the forthcoming health system reform initiatives are yet to be determined. Because PA education so closely resembles a condensed version of medical school, many of the same factors that complicate physician education and distribution are similarly experienced by the PA profession.

The argument that increasing existing PA program enrollment is less expensive than developing completely new programs must be tempered with the realities of increasing institutional competition for fixed educational resources. For example, AHCs with both a medical school and a PA program may not be able to absorb the added expense, space, and time requirements of more lecture commitments by basic science faculty, resident physicians, and staff attendings; more classroom space; and more competition for already limited teaching time on ward rounds, in the clinics, and in operating rooms. Additionally, the simultaneous demand to produce more generalist physicians may increase competition among medical schools, residency programs, and PA programs for sites for quality primary care clinical education. President Clinton's Health Security Act includes favorable provisions affecting PAs, but many questions relating to the prospective roles for PAs remain unanswered. The Health Security Act does not specify how the annual $400 million allocated for primary care education among medical schools, nursing schools, and PA programs is intended to be distributed.

Although a number of proposals suggest differing roles for midlevel providers within the context of health system reform,[1,2,4,5,46,55] the fact remains that PAs are inextricably dependent on physicians for their employment and supervision. The position stated by the American Boards of Family Practice and Internal Medicine opposing independent practice by nonphysician professionals also reflects the position of the PA profession.[56] The American Academy of Physician Assistants reaffirmed that the PA profession does not seek independent practice, direct reimbursement from third-party payers, or federal preemption of state practice acts.[57] Nevertheless, if health system reform initiatives include a greater role for PAs in the provision of health care, greater efforts must be made to improve the linkages and relationships between and among PA programs, medical schools, and generalist physician residency training programs. Introducing more medical students and

residents to the roles, functions, and capabilities of the physician-PA team in educational settings might reduce the existing degree of reluctance to "work together in well-integrated teams to enhance the quality and availability of cost-effective patient care," as called for by the American Boards of Family Practice and Internal Medicine.[56(p315)]

While the PA profession acknowledges the importance of working closely with physicians, the trend of increasing specialty practice of PAs is a topic of ongoing debate between generalist and specialty PAs.[58-60] Some generalist PAs are critical of the splintering effect of professional alignment with specialty groups, whereas some specialty PAs berate their reluctance to expand with the job market. Notwithstanding the specialty vs primary care rift within the PA profession, national health system reform measures will help determine whether PAs will continue to gain acceptance and legitimacy. Although the PA profession is faced with several obstacles to growth and expanded provider roles, success or failure in a changing environment will be measured by the profession's ability to meet the needs of the medical marketplace.

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'I have more time than most physicians to spend with patients'

Name: Joan Schulhoff

Background: Schulhoff, 44, moved to Chicago 18 years ago to work for Mt. Sinai Hospital Medical Center. She has a bachelor's degree in English from the University of Cincinnati and a Physician Assistant Associate Degree from Cincinnati Technical College. Schulhoff is currently director of Federation Programs for Mt. Sinai, which runs screening and primary-care programs for Soviet Jewish refugees and community-outreach programs for the Jewish community.

Years on the job: 18

TRIBUNE PHOTO BY NANCY STONE

PHYSICIAN ASSISTANTS ARE trained at a level above nurses and below physicians. Though we do about 80 percent of what a physician can do, we must work with a physician, not independently. We do histories and physical exams. We diagnose and we treat. And we do that through a set of verbal guidelines with our physician. We work with our physician for a while, and we take on his or her style of practice.

The reason PA's and other nonphysician providers are becoming so important is that there simply are not enough primary-care physicians in this country. And it's not just in rural areas. There are many underserved people in urban areas as well.

Most of what I see in my practice are things that the physician doesn't need to be doing: pre-employment physicals, colds, strep throats, sprained ankles, stable diabetics, stable hypertensives. When something exceeds my abilities, then I talk to the physician.

The physician I work with reviews the chart and signs it and periodically sees the patient. And the patient always has the option of seeing the physician. But the interesting thing is, the patient very often wants to see a PA because we have a little more time.

In 35 states, plus the District of Columbia and the Armed Forces, PA's can write prescriptions. In Illinois we don't yet have prescriptive privileges, but I believe that's changing. In an urban area such as Chicago it's easy to get the physician's signature on a prescription, but in rural areas, such as in Downstate Illinois, sometimes the doctor isn't around for a couple of weeks. So the PA's really need prescriptive privileges in those areas.

The Touhy Health Center is the facility where most of the refugees from the former Soviet Union receive their first medical examination after arriving in Chicago. We have more than 800 patient visits a month, most of them refugees; others are HMO patients or Medicaid patients. I'm responsible for programming, policy procedure and overall quality in this office.

Patients come in for a 2½-day medical evaluation, often within five or six days of arriving in the U.S., which is unlike any other city in the country, where they usually have to wait weeks and sometimes months to get in. We've also met planes at the airport when we've had notification that people will be arriving in bad condition, and we've gotten people directly into the hospital.

Our goal is to evaluate people immediately. They often come in with undiagnosed diseases, no medication, morbid hypertension, unstable angina pectoris, cancers that have not been diagnosed, terrible lesions, grotesque medical problems. We intervene as quickly as possible. We don't just do a public health screening—we do a whole primary-care screening, and PA's do that whole initial screening. If patients need ongoing care—and many of them do—they are sent to Mt. Sinai or Michael Reese Hospital.

On a typical day I start at around 10:30 in the morning, but I generally work till 9 in the evening at the Touhy Health Center and until 11 or 12 at the facility in Skokie. Most days I'll see eight to 10 new patients, many who have come in fresh off the plane. Some of these folks are healthy. But many have serious diseases, no medication or medications that have no U.S. equivalent. I have learned Russian so I can speak to the Russian patients, who make up the majority of our immigrant patients.

I get a complete history and do a complete head-to-toe physical with each new patient. Then I order appropriate laboratory work. The next day I go over everything with the patient—what I found on the physical, what we found on the laboratory work. We go through their bagful of Russian medications and determine which they may take, which would be dangerous for them to take; I substitute some American medications. I also go over the case with the physician and describe my plan and get the physician's approval.

"The quality-of-care studies that have been done are just wonderful for PA's. Malpractice claims are almost non-existent."

On other days I consult with doctors or go to meetings with a variety of organizations and individuals. Then there's the occasional house call for patients who are afraid to come out. Usually we've seen other members of the family, and then we hear that there's a grandmother or grandfather in the home.

What I like about this work is that I have more time than most physicians to spend with patients. I have the best of both worlds. PA's spend a little more time on health promotion and prevention as well.

One of the most touching incidents I've had was a teen-age girl who came to me for birth control. While I'm all for giving birth control to people who are sexually active, I had a sense from talking to her that she wasn't. When she came back for her exam, she was holding a stuffed doll, and I knew she was trying to tell me she wasn't ready. So we talked about it, and she agreed that she would wait six months. And she kept her part of the bargain and decided not to have sex for another year.

There are challenges, though, that I wonder if I'm going to overcome. When you have a program that loses money, you always wonder if you'll have enough glue to keep things together.

The profession, which is about 25 years old, has blossomed in the last couple of years because there's a growing awareness that there are areas where there is not enough care. And, gradually, even organized medicine has begun to realize that physicians can't do everything. The quality-of-care studies that have been done are just wonderful for PA's. Malpractice claims are almost non-existent.

To be a good PA, you have to have a strong academic background. There are no programs that will take anybody directly out of high school. The courses are very rigorous, and some are taken with medical students. You have to have good academic credentials, especially in the sciences. They also prefer people with prior health-care experience because you're thrown in with patients from the beginning. You're on a team, seeing patients with a physician, a fourth-year medical student, a resident and a PA student. You've got to be a mature person. ■

Interview by free-lance writer Norma Libman.

HEALTH-CARE REFORM

In S. Dakota, problem is plain — too few doctors

State typifies the problems of medical care in rural areas

By Richard Wolf
USA TODAY

WALL, S.D. — Nestled between the Badlands and the Black Hills deep in cattle country, health-care reform is a four-letter word: Dave.

Forget managed competition, employer mandates and a menu of health plans. The ranchers and farmers out here — 30 miles from the nearest doctor and hospital — are dependent on physician assistant Dave Custis for their care.

"I do all my own X-rays, I draw all the blood, I give all the shots," Custis says, while juggling his Wall Clinic caseload of colicky infants, frail Medicare patients and occasional emergencies. "We're out here on the front line of medicine, and we don't have the technology to go with it."

The slice of rural America Hillary Rodham Clinton visits today in Lennox, S.D., needs health-care help far more basic than the complex prescriptions now under review in Washington, to solve problems far more life-threatening:

▶ Manpower. Doctors are hard to find and keep, making physician assistants, nurse-practitioners and county nurses a godsend for people in small towns. The nation has one doctor for every 400 people; in South Dakota, it's one for 600.

▶ Distances. When emergencies or illnesses are too much for those front-line medics to handle, it's not unusual for expectant mothers, accident victims or heart-attack patients to travel an hour or two to the nearest hospital.

In the 1940s, South Dakota had doctors in 165 places. Today they're at just 69 locations.

▶ Money. Rising insurance premiums and medical bills take a toll on a population dominated by the elderly, the self-employed and small businesses. Clinics and hospitals struggle to balance books, with lower federal reimbursements.

All those hardships come together in places like Wall, home of Wall Drug Store. Billboards all along Interstate 90 tout the store's 5-cent coffee and buffalo burgers.

Custis sees 6,000 patients annually and sends some an hour away to Rapid City. The clinic, which lost its lone doctor in 1991, turned a $985 profit last year — far short of the mark needed to get Custis some help.

"If we didn't have 'Doc,' we would be lost," says Betty Dunker, 43, who visits Custis for anything from a bad cold to treatment for multiple sclerosis. "He'll make house calls."

That's the kind of care required in rural America:

▶ It's home to one-quarter of the U.S. population, but more than one-half of all Americans living in areas officially designated as short on doctors.

▶ More than 14% of rural residents go without insurance for at least a year; 18% of farm families lack insurance.

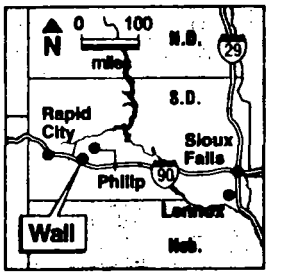
The South Dakota story is like others. About 100,000 residents, one-seventh of the population, go "bare" — without insurance. Two-thirds of the state has a shortage of primary care.

"Health care is tentative. You can't count on it," says Sen. Tom Daschle, D-S.D., as he pilots a plane to Wall to meet with ranchers.

At the Wall Clinic, mammograms are a road show from Rapid City, a dentist stops by once a week, and orthodontia is offered every six weeks.

By Matthew Kryger

ON THE FRONT LINES: Physician assistant Dave Custis examines Betty Dunker in Wall, S.D. The nation has one doctor for every 400 people; in South Dakota, it's one for 600.



USA TODAY

Thirty miles east in Philip, two doctors staff a clinic, 20-bed hospital and 30-bed nursing home for the area's 3,500 people. They're the only doctors between Pierre and Rapid City, a distance of about 150 miles — and their stories illustrate the manpower problem.

▶ George Manguils, 71, is a Latvian-born doctor with a medical degree from Germany who has hunkered down in western South Dakota for four decades. Over the years, U.S.-educated doctors recruited to help him have come and gone.

"We are like a transit station," Manguils says. "We are struggling about how to make the ends meet."

▶ Coenraad Klopper, 46, is a South African doctor recruited in 1991 from Saskatchewan after battles over residency and certification. Unlike his predecessors, he has remained, but, as Manguils reduces his l , Klopper is overworked.

"We do anything which comes along," he says. "Out here, you're it. You don't have any off time. You can't go anywhere, you can't do anything."

To these and other rural Americans, health-care reform holds both promise and peril.

▶ Among the promises are incentives aimed at boosting the number of medical school graduates who enter primary care, placing them in rural areas and expanding the roles of non-physician providers.

▶ Among the perils are additional cuts in Medicare, which could further reduce already restrictive rural reimbursement rates, and a system of mandatory consumer purchasing groups that could prove difficult to implement in sparsely populated states.

Those new alliances — plus mandates that employers provide insurance, and price caps on insurance premiums — are supposed to create President Clinton's vision of ' aged competition."

But in Wall, where there's just one physician assistant few insurance plans, there's no competition to manage.

Says Daschle, a defender of the Clinton plan: "There is a realization that you can't run South Dakota's health care program like New York or Florida would run theirs."

Assistants, nurses: same but different

Madison, WI 1-15-94

By Scott Russell
The Capital Times

Physician assistants and nurse practitioners cite two reasons for choosing their professions: They work fewer hours than doctors yet have more autonomy than many other health care professionals.

And while they are technically supervised by a physician, they say on a practical basis they are given the opportunity to work with patients one-on-one unless something unusual pops up and requires a doctor.

"I get asked: 'Don't you want to go on and become a doctor?' " said Monica Stanek-Dieter. "The answer is 'no.' I like my level of involvement with patients. I like my level of responsibility and time commitment. It's the best of two worlds."

Stanek-Dieter is a certified nurse practitioner in the DeForest satellite office of the Monona Grove Clinic.

For Nadine Kroenke, a fourth-year student in the University of Wisconsin-Madison's physician assistant program, priorities in her career choice included the pace of her daily schedule and shared responsibility.

"I don't want to feel rushed with my patients," she said. "I wanted to be part of a team. I didn't see it as a prestige thing."

When it comes to choosing between being a PA or an NP, the decision may rest with a preference for one type of training over another.

Some physician assistants claim their training is more solidly rooted in diagnosis and treatment of disease than training for nurses.

David Wilson, also a fourth-year PA student, worked 10 years as a registered nurse before making the switch. During some of those years he worked as the tranplant coordinator at University Hospital.

> 'I like my level of involvement with patients. I like my level of responsibility and time commitment. It's the best of two worlds.'
>
> MONICA STANEK-DIETER

"PAs are trained to think and act like physicians," he said. "I chose to become a physician assistant over a nurse practitioner because I wanted more training in the medical model than nursing gives you."

Under the nursing model, the diagnosis is already there, he said. "You take care of all the patient's needs, their emotional well-being. You're with them all the time."

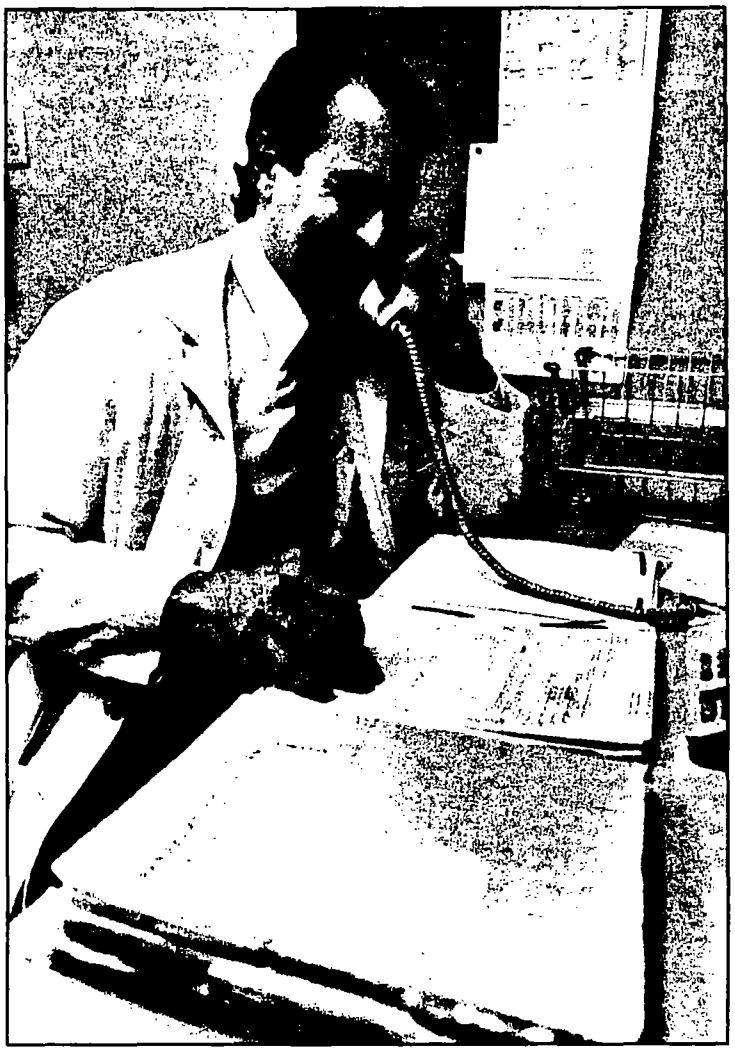
"Nurses provide the best care," Wilson said. "They do not make the diagnosis."

Nurse practitioners would argue that they receive diagnostic training in school as well as additional education on broader health care issues.

"We do have the medical training within our curriculum," said Terri Patwell, a nurse practitioner at the Black Earth Clinic. "I also learned about health maintenance and prevention. I see our role here as keeping patients as well as they can be."

Patwell said she thought about going to school to be a physician assistant, but decided against it because in her heart she knew she was a nurse.

"The background of the nurse — we are really professional caregivers," she said. "Even though I do a lot of the same things a physician assistant does, my nursing background has influenced how I work."



DAVID SANDELL/THE CAPITAL TIMES

Lou Falligant (above), president-elect of the Wisconsin Academy of Physician Assistants, entered the field when it was just getting off the ground in the mid 1970s. Work was sporadic, but now the profession has reached its stride, Falligant said.

Those whose job it is to train physician assistants and nurse practitioners diplomatically dismiss the question of professional friction between the two fields.

"There were difficulties early on," said Forrest Girdley, head of the UW-Madison physician assistant program. "Those have largely disappeared."

Vivian Littlefield, dean of the UW-Madison's School of Nursing, said it's important to think about the contributions of both professions, "rather than whether one is better than another."

People entering either profession can expect healthy job opportunities. But that was not always the case.

Lou Falligant, president-elect of the Wisconsin Academy of Physician Assistants, entered the field when it was just getting off the ground in the mid 1970s. Work was sporadic. He ended up working in Buffalo County in central Wisconsin.

"I wrote several hundred letters looking for a job," he said. "I only got two or three responses."

But now the profession has reached its stride, Falligant said. "We have people ask us how their children can become a physician assistant. It's certainly more fun to answer that than the question: 'What's a physician assistant?' "

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First of state's physician assistants begin entering the medical system

By DONNA LEUSNER

Physician assistants are slowly beginning to practice medicine alongside New Jersey doctors after 20 years of resistance from the medical community and a year-and-a-half after Gov. Jim Florio signed a law allowing them to work in the state.

The first five licenses were approved by the state Board of Medical Examiners on July 14, although a dozen physician assistants began working in hospitals two years ago as part of a pilot project.

Working under the supervision of physicians, physician assistants can perform at least 70 percent of the clinical duties of general practitioners, allowing doctors to concentrate on more complex patient problems.

Physician assistants can record patient histories, give physical exams and injections, draw blood, take patient histories, remove sutures and administer medication.

At least 23,000 physician assistants are working around the country. In fact, New Jersey was the 49th state to pass a law allowing them to practice here; only Mississippi still prohibits their licensing.

Hospitals, operating in a new deregulated market in which competition is based on price, are anxious to have another member of the health care team, especially one who can be hired after three years of classroom and clinical training for $40,000 to $60,000—less than half the price of a general practitioner.

Beyond the walls of hospitals, physician assistants can be a valuable asset in community health facilities like the HIV clinic run by St. Michael's Medical Center in Newark or the city health department clinic.

Sister Dolores Lew divides her time between both places, learning how to examine, manage and treat patients with sexually transmitted diseases and HIV as part of her third and final year in the physician assistant program run by Rutgers University and the University of Medicine and Dentistry of New Jersey.

"There is a great need for PAs. We could alleviate 70 to 85 percent of a physician's workload and he can spend quality time with those who are more ill. We can stretch our hands to patients to help give medical care," said Lew, who spent 15 years as a medical

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Physician assistants entering medical system

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technologist and blood bank specialist.

"I wanted more patient contact," said Lew, a member of the Sisters of Charity. She wants to work with the poor and treat patients physically as well as spiritually.

"I'm just sorry that some of the physicians are not open-minded to the need," she added.

For years, the state Medical Society and the state Nurses Association lobbied to keep physician assistants from practicing in New Jersey, arguing that the quality of care would suffer and that it would wind up costing the health care system more to add another layer of professionals between doctors and nurses.

"Contrary to what my friends in the Medical Society think, it improves the quality of care. Our experience here has been very positive," said Dr. Fred Jacobs, president of the state Board of Medical Examiners.

The two physician assistants who have worked in neurosurgery and orthopedics at St. Barnabas Medical Center in Livingston, where Jacobs is senior vice president for medical affairs, have worked out "extraordinarily well," he said.

Some of the hospital's medical staff members were ambivalent at first, Jacobs conceded. "Now you find doctors on our staff who were opposed to this who want to hire their own PAs," he said.

Dr. Sophie Pierog, vice president and director of the pediatrics department at Jersey City Medical Center, said she too expected problems with residents, nurses and doctors adapting to the three physician assistants working there under the pilot project.

Photo by Rich Krauss

Joseph Thornton, clinical coordinator of the physician assistant program at Robert Wood Johnson Medical School in Piscataway, watches as Sister Dolores Lew of Convent Station performs an ear examination on fellow student Linda Greer of Millstone

"But we've had smooth sailing," said Pierog, who hopes to "multiply by a dozen" the one physician assistant she has working in pediatrics.

"Any extra help is always welcome," said Dr. Michele Reisner, the director of the emergency room at Jersey City, where she supervises a physician assistant. "I certainly would welcome more PAs in the emergency room."

Physician assistants are also working at University Hospital in Newark and Cooper Medical Center in Camden. They have worked for years in Veterans Administration hospitals and prisons in New Jersey run by the federal government.

Physician assistants who led the fight to be licensed in New Jersey and state officials who have worked on implementing the new law say the year-and-a-half delay is not unusual to get a new category of health care professional working. It takes that long, here and in other states, to develop the rules and licensing procedures for a new category of professional, they said.

"It is not easy to get a license in New Jersey," Jacobs said. "I don't apologize for that. It should not be easy. I want to make sure these people who apply are who they say they are."

The 17-member Board of Medical Examiners he heads licenses physician assistants.

"While it takes a little longer, it serves the public," Jacobs said.

Nicole Gara, director of government and professional affairs at the American Academy of Physician Assistants, said some states have taken about the same amount of time and others longer. Missouri took a year and a half. The Pennsylvania Medical Board has taken seven years to rewrite its rules after a law was passed removing authority from the board of pharmacy.

It took 18 months after New Jersey passed a law allowing respiratory therapists to practice before regulations were adopted, according to Marianne Kehoe, executive director of the physician assistant advisory committee. There are about 50 physician assistant applications in varying stages of approval, Kehoe said.

Joseph Thornton, president of the New Jersey Society of Physician Assistants and one of the first five applicants to have their licenses approved, said things are not moving as fast as he would have liked but he has seen no evidence that anyone is being "obstructionist."

Ruth Fixelle, director of the Rutgers-UMDNJ physician assistant program, said she did think the delay was "really unusually long." She said the medical board had been more "cooperative and helpful than we anticipated." Fixelle was also among the first five physician assistants granted licenses earlier this month.

New Jersey graduates have scored the highest in the country over the past few years on the national physical assistant exam, but until now they have had to look elsewhere for work. There are about 300 physician assistants living in New Jersey but working elsewhere, Thorton said.

Because they are in demand – seven jobs are waiting for every new graduate nationally – New Jersey hospitals have some recruiting to do to bring back physician assistants to the state to work, a hospital association official said.

In the meantime, physician assistants are starting a new fight. They want a bill passed (A-2806/S-1943) that would allow them to get temporary licenses between the time they graduate in May, take a national exam in October and get the results back in late January.

also ran July 7, 1993 in Allied Health Section

Judge

Nelson

Patchin

Do APNs need doctor supervision?

NP, physician and PA face off

Health-care delivery is undergoing radical surgery as lawmakers and providers grapple with the need to expand access to health care without compromising the quality of patient services.

The gap between the demand for primary care and the number of available physician providers likely will be bridged by non-physician professionals, advance-practice nurses (APNs) and physician assistants (PAs).

As APNs pursue a career agenda that will give them more autonomy, they are encountering opposition from both doctors and PAs who say physician supervision is essential.

How important is physician supervision of nurses and/or PAs to the integrity of the health-care system? Should APN primary-care specialists—nurse practitioners—be encouraged to work independently, that is, not under the direction of a physician?

We asked a nurse practitioner, a physician assistant and a doctor who worked as an RN for 15 years to comment on the emerging independent role of nurse practitioners. (Our panel's telephone-conference dialog has been edited for space.)

***Judge, RN, MSN,** a certified primary-care nurse practitioner at the University Health Service at the University of Chicago, is chairperson of the Illinois Nurses Association Council of Nurse Practitioners, Chicago.*

***Ron Nelson,** a certified physician assistant at Cedar Springs Medical Center, Cedar Springs, Mich., is the former president of the American Academy of Physician Assistants.*

***Dr. Rebecca Patchin,** a fourth-year resident in anesthesiology at Loma Linda University Medical Center, Loma Linda, Calif., worked as a registered nurse in critical care and pediatrics from 1969 to 1984, before entering medical school in 1985.*

Judge: Of course nurse practitioners should work independently within their scope of practice! Supervision of nursing functions by a physician is not necessary. Collaboration with a physician, however, for practical purposes, is always necessary, unless a nurse is performing only nursing functions.

There are some areas of overlap (of nursing care and physician care), but I don't think supervision is necessary. There are many studies that show that.

Nelson: Nursing activities are best defined by the nursing profession itself. My belief—and the belief of the PA profession—is that the practice of medicine by PAs requires the supervision of a physician. And that supervision should be defined by the physician, the PA and the state's practice code.

Patchin: I think there are some (nursing functions) that may not require direct physician supervision. Incidentally, I personally prefer the terms collaboration and collaborative practice.

Above all, we must remember that each patient is a whole person and that we can't diyide a human being into separate territories of nursing practice (and) medical. . . . It's sometimes difficult to define where the nurse's scope of practice and the physician's scope of practice begins and ends.

But if there are times when collaboration is indicated and necessary, then I think we've answered the question: "Should nurses work independently?" I say no.

Judge: I'm sort of uncomfortable that we're (debating) independent practice by nurses, even though nurses are out in rural areas (where physicians are scarce) and practicing independently right now—and that's okay.

Patchin: The quality of care should be the same for everyone, whether they live in a rural community, or an affluent suburban community, or an inner-city ghetto. . . . The best way to consistantly deliver quality health care is for all parties—doctors, nurses and PAs—to sit down together and agree on the scope of practice for each, which may depend upon the skills of the individual as well as the practice setting.

Nelson: One of the problems that we've experienced is what I refer to as the smoke and mirrors of collaboration and supervision . . . Hopefully, we all know what our limitations are, and that's what makes us adequate and good professionals.

We're all interested in promoting better delivery of health-care services, and that requires someone to be the head of the team. Someone has to be the captain of the ship. Obviously the physician, in terms of education and background, is the individual to provide that kind of direction and supervision.

Judge: Nurse practitioners are not proposing to do medical care. We are providing health care. Incidentally, I just have to get on record as saying I don't agree with the doctrine that the captain of the ship is the physician.

Reporter: Who is better prepared to provide primary care, a nurse practitioner who is working without direct supervision or the physician assistant who is always under a physician's supervision?

Patchin: Obviously, it's nice to have things black and white. I personally don't see that you can say who is best and who is worse. You have to look at the educational preparation and the situation.

Nelson: I really don't think education is the issue. The issue is the (provider's) qualifications to completely take care of patients. PAs are trained in the physician model; they're trained to manage patients using the same approaches that are taught to physicians.

Judge: I don't think we have to decide who's best prepared to give care. The fact is there are not enough primary-care providers.

Nelson: The bottom line is the safe practice of medicine by PAs requires a supervisory relationship. And that supervisory relationship is determined by state law, the physician and the practicing PA.

The team approach to health care is still the most effective model for delivery of health-care services. . . . PAs are part of that equation.

Judge: (Expanded) primary health-care services are basic to effective health-care reform . . . What's really important to nurse practitioners, so we can continue to provide access to that care, is professional recognition, (which includes) prescriptive authority and direct reimbursement.

Patchin: I worked (as an RN) in a physician's office for a year with a family practicer and a pediatrician, and was using some on-the-job training skills at that time to do pediatric well-baby checks and female physical assessments . . . When I looked at my future life and career, I made a decision to go (to medical school), rather than to go into advance-practice nursing. That was a conscious decision. And it was based on my belief then, and my continuing belief, that the physician is the captain of the ship.

We need to ensure that our citizens have access to quality health care. I believe the best way to ensure that is through a team or collaborative approach. And to me, that does not mean having independent (APN or PA) practices.

Interviews by Mary Peterson Kauffold RN, a Chicago freelance writer.

'War' looms as APNs seek independence

Chicago Tribune June 30, 1993, Special Section

By Mary Peterson Kauffold, RN

Advance-practice nurses are determined to shed the last vestige of their physician handmaiden image and win the respect, autonomy and remuneration that they say still eludes them—even if it takes an act of congress in the name of health-care reform.

Both physician and nurse groups are marshalling their member forces in what may be the most volatile health-care turf battle in a long time.

At issue "is money and control," said Nancy McGinn, RN, MSN, a certified nurse practitioner who is a staff specialist in workplace advocacy for the American Nurses Association.

The ANA's position is clear: The time is long overdue to make prescriptive privileges and direct reimbursement for services legal nationwide for advance-practice nurses (APNs), who count among their ranks about 30,000 nurse practitioners, 5,000 nurse midwives, 40,000 clinical nurse specialists and 25,000 nurse anesthetists.

The ANA solution to the shortage of primary-care providers is simple: Rethink the definition of provider. "Some 60 to 80 percent of primary and preventive care traditionally done by doctors can be done by [an APN] for less money," asserts an ANA publication.

"That's where the rubber hits the road," said Dr. M. Roy Schwarz, senior vice president of medical education and science at the American Medical Association. "That's where the professions sharply divide. We'll forever be divided on that issue, because medicine believes nurses are not adequately trained to play the role of doctor."

"The quality-of-care argument just doesn't hold water," said Jan Towers, PhD, a certified nurse practitioner and director of governmental affairs and research for the American Academy of Nurse Practitioners. "We've been providing primary care for 25 years, and our insurance liability rates are extremely low."

APNs are not trying to be pseudo-physicians, stressed McGinn. Their goal is not to practice medicine. APNs seek to provide health-care services that are clearly within their scope of nursing expertise and, if they so chose, to provide them independent of physician supervision, she said.

This, however, amounts to a call to political arms for the AMA, said Schwarz. "I think we're going to have a terrible political fight," he said. "It's been going on at the state level, with skirmishes here and there . . . but it's reached a level where they [nurses] are challenging some fundamental assumptions on which the profession of medicine is built."

"They [ANA officials] think this is the time—in this climate of health-care reform, cost containment and [shortage] of primary-care physicians—to press their agenda. . . . I've tried to tell people in leadership roles in nursing that a war is inevitable [if they continue their efforts]."

The fray is complicated by a third group—a contingent of an estimated 25,000 physician assistants (PAs). PAs perform many of the same services as APNs, but always work under the supervision of physicians.

Tradition has long lumped APNs and PAs together under the umbrella title of physician extenders, but many nurses regard the term as demeaning. APNs contend they are not extensions; they are collaborators with physicians. They point out that most APNs have a master's degree, whereas PAs can practice after they complete a 24-month training program and pass a national certification exam.

PAs square off opposite nurses in the supervision debate. The doctrine that the health-care team has one captain, and that person is the physician, is virtually dogma at the American Academy of Physician Assistants.

Physicians have a vested interest in promoting the PAs-as-captive-workforce model, said McGinn. "Physicians control everything completely with PAs; they control their practices and they control their salaries," McGinn said.

Many health-care payers—including government agencies, health insurance companies and health maintenance organizations—have virtually held APN independence hostage by funneling nurses' fees through

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War

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supervising physicians who may do little more than sign-off on claim forms, said Leah Binder, director of public relations for the National League for Nursing. That required signature not only has a price—a chunk of the fee—it also "restricts entrepreneurism among nurses," Binder said.

The ticket to liberating nurses from what amounts to an economic lock-out is to directly reimburse nurses for their services, McGinn said.

The AMA's Schwarz vows that if APNs get the legislative changes they want, and throngs of them begin to hang out shingles across the street from physicians' offices, "the war will just continue."

In a protracted doctor versus APN battle, physician scrutiny of nurses likely would be the fodder, said Linda Tinson, RN, BSN, a certified nurse practitioner who works at Cook County Hospital. "This is a scary time," she said. "There are going to be a lot more eyes watching you and waiting for you to make any little mistake, so they can say, 'I told you so.'"

What nurses can do legally on their own initiative remains blurred in the minds of many APNs who want to be independent. But what if state and federal laws were enacted that spelled out the rights and practice territories of APNs? "Within two years," predicted Binder, "instead of calling your doctor when you're sick, you'll call your nurse."

Mary Peterson Kauffold is a Chicago freelance writer.