

FIRST LADY HILLARY RODHAM CLINTON

REMARKS TO THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

(VIA SATELLITE)

MAY 25, 1994

DRAFT

GOOD MORNING:

I am pleased to have the opportunity to speak to you today. I'm sorry that I cannot be with you in person, but I'm glad the information superhighway has an exit in your vicinity.

My thanks to Stephen Crane [AAPA Executive Director], for his kind invitation to speak with you today and to Ann Elderkin [AAPA National President] for her gracious introduction.

Let me first say a few words about your remarkable profession. In just 30 years, we've seen the number of physician assistant programs grow from a single revolutionary embryo at Duke University to 58 accredited programs in 29 states and the District of Columbia. Today, more than 23,000 physician assistants are practicing in nearly every state of this country - more than half of them in primary care. And that number is expected to grow by another 44 percent by the year 2005.

This meeting comes at a critical juncture in our national debate over health care reform. Here in Washington, the five major Congressional committees handling reform are moving forward and the action so far is quite gratifying.

One reason the health care debate has come so far is the hard work of people like you. Physician assistants know better than anyone else the gaping holes that exist in our current health care system. You see the evidence every day.

You see the uninsured pregnant woman who comes in for prenatal care five months late because she was too embarrassed to admit she had no coverage.

You see the underinsured family that brings their children in for immunizations only after the first case of measles or mumps occurs. The kind of thing that leads to the outbreak of measles now afflicting the residents of Saint Louis.

And you see the elderly woman living in a nursing home, instead of being at home with her family, because she has no access to home or community-based care.

You do all this while fighting against rules and regulations that frequently try to squeeze you out or shut you down.

And you provide the kind of humane, hands-on care that the people of our nation hunger for -- the personal touch that makes the difference between dignity and despair for people in need.

I often say that the health care profession is a story of heroes. Heroes like Dave Custis, a physician assistant who practices in the town of Wall, South Dakota.

In a typical day, Mr. Custis will immunize a child, stitch a wound, and visit a senior citizen in a nursing home. Like all of you, he has to be a jack-of-all-trades, and his professional training allows him to be just that.

In a town like Wall, where Mr. Custis is the only health professional in practice, or in a city like San Antonio, where physician assistants work hand-in-hand with doctors and nurses, you all provide a vital service.

But performing that important job is becoming more and more difficult as the pressures of the current system constrain your profession. Every day, you must confront a system that has too much red tape and not enough coverage.

One of our goals in health care reform is to create a seamless system of health care for all Americans.

We want to make it easier for men and women like you to use your skills and expertise to provide the very best care for your patients.

To do that, we must have a system that makes sense.

It must provide the security of guaranteed private health coverage for all Americans with a comprehensive benefit package that emphasizes prevention and primary care.

It must provide people a choice of health plans and health care professionals.

It must get rid of hard-hearted insurance rules that kick people when they're down.

It must preserve and improve the Medicare program for our senior citizens.

And it must make sure that people who get up every day and go to work have a job that includes health insurance.

Those principles are at the center of the President's health care proposal.

As we rebuild our system to meet the needs of our people, you will play an even larger role than you do today. If we simply hand every American a health security card we will not finish the job unless there are qualified health professionals ready to provide those services.

We will need you to continue your remarkable growth as a profession so that the promises we make today as part of health care reform will become the realities of tomorrow.

The President's Health Security Act embraces physician assistants as part of the health care delivery team that will provide the comprehensive benefits guaranteed to every American.

It includes PAs in a list of potential essential community providers.

It authorizes \$400 million dollars in new funding to train primary care physicians and physician assistants.

It extends Medicare coverage for outpatient services provided by PAs to all geographic areas. And it provides direct reimbursement to PAs who provide those services.

Finally, it seeks to develop a model professional practice statute for PAs and other health professionals to make sure that we utilize all of your talents and all of your skills.

These are steps that must be taken if we are to guarantee our citizens access to high-quality, affordable health care.

One of the things the President is proud of accomplishing during his 12 years as governor of the state of Arkansas was a law broadening the responsibilities of physician assistants. Passing that legislation took a lot of hard work, and it has paid off in better care for thousands of Arkansans.

Today, the challenge before us is even bigger -- but the potential payoff is even greater still.

Together we will take this giant step forward to a new and secure system of health care that maximizes the skills of talented health professionals like you and improves the lives of millions of Americans.

Thank you.



FAX TRANSMISSION

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Office of the Secretary

DATE: May 23, 1994
TO: Lissa Maccatone
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COMMENTS:

Draft remarks for Wed., May 25.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

M E M O R A N D U M

To: Lissa Muscatine
From: Richard Sorian and Dan Porterfield^{RS}
Subject: Draft Remarks for First Lady to the American Academy of Physician Assistants
Date: 5/23/94

Attached are draft remarks for the First Lady's satellite appearance before the American Academy of Physician Assistants on Wednesday, May 25. We tried to keep them short and would be glad to pare back further if needed.

Most of the AAPA folks are out of pocket already in San Antonio. However, the home office tells us that Connie Szostak (Show-stack) will be in tomorrow and could take a look if you would like. Her number is (703) 836-2272 and her Fax is (703) 684-1924.

Let us know if you need anything else. Otherwise, see you tomorrow.

Thanks.

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FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

(VIA SATELLITE)

low-income.

MAY 25, 1994

Health security

DRAFT

*Thank = for help
in crafting legis/in-*

GOOD MORNING:

~~Ann Elderkin - Nat'l Pres AAPA~~
~~Steve Crane exec. UK.~~

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Thank you.

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COMMENTS: Background Info for
Phys. Asst Remarks

Thx!

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August 15, 1993, Sunday, Late Edition - Final

SECTION: Section 6; Page 25; Column 1; Magazine Desk

LENGTH: 5123 words

HEADLINE: The Anguished Politics of Breast Cancer

BYLINE: By Susan Ferraro; Susan Ferraro writes frequently on women's issues.

BODY:

Something happened to Liz Lorusso during radiation treatment for breast cancer. "I asked to be covered," she says, "and this guy, the technician, told me, 'There's no modesty in a hospital; only 80-year-old women get upset over this.' I went home and that statement ate at me all night, just like a cancer."

The next day, once again lying face up on the table, she looked at the technician and said: "Do you remember what you said to me yesterday about modesty? Well, you go get your testicles cut off, lose every hair on your body from the top of your head to the tip of your toes, then lie down on this table and have someone draw all over your crotch with a Magic Marker and we'll see how you like it."

LoRusso discovered the lump in her breast four years ago. She was 37. The lump turned out to be advanced third-stage cancer. The disease, which traveled to her spine and pelvis, now is "under control." She has started taking tamoxifen, a drug prescribed in an experimental cancer-prevention program -- the first of its kind.

"I was never political, never," says LoRusso, a home economics teacher who is on disability leave. She lives in Huntington, L.I., in a pleasant two-story ranch, and chauffeurs her two kids after school, runs errands and frets about dinner and dust. "I was the peacemaker, the people pleaser. I had 16 years of Catholic school. The nuns said 'Jump.' I said, 'How high?' "

Liz LoRusso is less obedient now. She has joined 1 in 9, an advocacy group that takes its name from a commonly quoted statistic on the incidence of breast cancer. These women ask hard questions about environmental factors that may lie behind Long Island's suspected cancer clusters and high breast cancer rate. LoRusso wonders if something in the environment played a part in her disease. She thinks the "establishment" has patronized women and neglected or ignored the facts about breast cancer.

"They said it could be cured, that I had 60 percent chance of no recurrence in five years," LoRusso says. "The truth is I had 60 percent chance of being alive in five years." Her voice slides into the supersweet sarcasm that very polite women use when they are very angry. "Don't you just love it? Isn't it just slightly misleading to confuse recurrence with survival?"

How many angry women does it take to make a revolution? Inspired by AIDS activists in the 1980's, women with breast cancer are turning scores of support groups into a national political advocacy movement. Most of them, like

The New York Times, August 15, 1993

LoRusso, are amateurs at activism, more comfortable speaking up for their children or their families than for themselves. The energy that drives them is anger. They say they've had it with politicians and physicians and scientists who "there, there" them with studies and statistics and treatments that suggest the disease is under control.

On the cover of a pamphlet about radiation therapy from the National Institutes of Health is a drawing of a woman receiving treatment. "She's fully clothed, she's got a blanket; she's even got a pillow." says LoRusso. "The reality is that where you once had a breast now resembles a page out of the Hagstrom road atlas. They put you on a slab, with a sheet. You're exposed They take Polaroid pictures and anyone can see because there's a TV camera with a monitor outside the room.

"They stroke your hand and say, 'Don't worry, you'll be all right.' I'm angry because I'm a realist."

There are more than 180 advocacy groups, including 1 in 9, united under the National Breast Cancer Coalition, a largely voluntary organization founded in 1991. The activists are demanding more money for research, and getting it. But they want more -- a big say in how that money is spent. They are impatient with research that focuses only on early detection and treatment rather than the causes of breast cancer.

"Early detection is not early enough," says Dr. Susan M. Love, director of the U.C.L.A. Breast Center and a co-founder of the coalition. The standard treatment is surgery, radiation and chemotherapy -- or as Love describes it, "slash, burn and poison."

The activists may be a health movement first, but theirs is a feminist cause as well: Many believe that breast cancer has been ignored for decades because it is a woman's disease. It may be wishful thinking on their part, but some activists suggest that breast cancer is the feminist issue of the 1990's.

"We have to be the voice, the obnoxious voice," Love says. "We can't shut up now."

So far, this obnoxious voice has been extraordinarily successful, surprising the women almost as much as they have surprised lawmakers. In its first year, the coalition secured a \$43 million increase in national funds for breast cancer research, an increase of almost 50 percent. The next year, armed with data from a seminar they financed, the women asked for, wheedled, negotiated and won a whopping \$300 million more.

They did it in part by mobilizing grass-roots support. The coalition fielded a drive for 175,000 signatures, one name for each woman who would get a diagnosis of breast cancer that year. In October 1992, "Breast Cancer Awareness Month," the coalition delivered not 175,000 but 600,000 signatures to Washington.

And they enlisted the support of a key friend -- Senator Tom Harkin, Democrat of Iowa. The result was an ingenious, even startling legislative maneuver that teamed them with the Department of Defense. This is not as crazy as it sounds. The Army has thousands of women in uniform, and in 1992 it budgeted \$25 million for screening and diagnosis of breast cancer. When Harkin was unable to

The New York Times, August 15, 1993

transfer funds from the defense budget to the domestic budget, he proposed that the Army's \$25 million be increased to \$210 million for breast cancer research.

Joanne Howes, the coalition's lobbyist, delights in telling how, when the votes went over the required 51 to pass the measure, senators who had opposed it rushed back to change their vote: "In the 'Year of the Woman,' they didn't dare go back and tell their constituents that they had voted against this successful strategy." The final tally was 87 to 4.

AS DEMONSTRATIONS IN WASHINGTON GO, THE National Breast Cancer Coalition's rally on this blazing Sunday afternoon in May is no big deal. The week before, more than 300,000 gay and lesbian Americans, many of them AIDS activists, had jammed the Washington Mall. Today only 700 or so demonstrators cluster on a patch of grass near the Reflecting Pool. There are no celebrities, no politicians looking for camera angles.

Yet the rhetoric, when it comes, is an unapologetic, confident roar of political rage. Especially riveting is Sherry Kohlenberg of Virginia. The mother of a 4-year-old boy, Kohlenberg, 37, is a small figure in black -- pale but fierce. Her straw hat wobbles on her head because chemotherapy has made her hair fall out.

"This year 46,000 women will die of breast cancer," she says. "I will probably be among these statistics. I will leave behind my husband and partner of 18 years, a motherless child, a devastated family and too many friends. I will not get to watch my son grow up, or grow old with my husband. And the worst part is that I am not alone. This family tragedy happens every time a new diagnosis is made, and every time a woman's life is stolen by breast cancer."

There is backlash, she says, when women speak out, but she doesn't care. "I will not go silently," Kohlenberg roars. "I will go shouting into that dark night; enough is enough."

On the sidelines, Kohlenberg's close friend, Kendra McCarthy, wipes away tears. "She's dying, and she knows it," McCarthy says. Angrily jabbing a finger toward the Capitol, visible over the trees, she adds: "We've gotten in those people's faces, and we're going to stay there."

If they see themselves as combatants in a life-or-death battle, breast cancer activists make an odd sort of army. They wear buttons and hats and T-shirts emblazoned with slogans: "Draw the Line at 1 in 9," "Silent No More!" and "The Wife You Save May Be Your Own."

Yet whatever their strength in numbers, they are scared individually, vulnerable. Worried that she might seem too critical of the medical personnel on whom she continues to rely, Liz LoRusso insists that although one radiation technician was insensitive, "The other technician was wonderful, a real source of inspiration; we prayed together."

They are achingly aware of their casualties, their walking wounded and the odds. On the way to the rally, Susan B. Kaplan, the treasurer of 1 in 9 and a patient with recurring breast cancer, discusses the language of mortality.

"I'd rather have chronic breast cancer than be Stage 4 terminal," she says, her matter-of-fact tone almost reassuring. "You have to believe that if you

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have a recurrence you'll get through it. People die of asthma too, but it's chronic. Chronic means it goes on."

EVEN SIGMUND FREUD COULD FIGURE out what these women want: Straight answers about a complicated disease that threatens their lives, and a coherent public policy based on those answers.

"When I was diagnosed I was stunned," says Frances Visco of Philadelphia, a lawyer and president of the coalition. Her son was a year old in 1987 when she learned she had breast cancer. "I had no family history, and I felt that meant that I was O.K., that I didn't have to worry about it. When I started reading of this disease, I thought I was seeing misprints. If this is true, why didn't I know about it?"

One reason, Love asserts, is that "the medical profession and the media have sort of colluded to make it sound like if you do your breast self-exam and you get your mammogram, your cancer will be found early and you'll be cured and life will be groovy."

Mammograms are the best diagnostic tool available, but by the time a cancer shows up on a mammogram, she says, it could have been there eight years, for much of that time having access to blood vessels that can ferry stray cancer cells to vital organs.

As recited by advocates at every opportunity, the statistics that don't get much publicity are startling. Right now, they say, 2.6 million women in the United States have breast cancer -- 1.6 million who know it, 1 million who don't.

Scientists know that smoking contributes to lung cancer and they know something about the gene that goes haywire in colon cancer, for example, but no one has any idea what causes breast cancer, the leading cause of death in women ages 35 to 52. The mortality rate for black women is 10 percent higher than for white women, although they get breast cancer less frequently. The overall mortality rate for breast cancer -- 27 deaths per 100,000 women -- has remained the same for 50 years, and its incidence has increased steadily in what the coalition insists is an "epidemic," though cancer specialists do not agree.

Even the identification of high-risk factors -- having a close relative with the disease, early menstruation, late menopause, giving birth late in life or not at all -- is not the news it seems to be. Depending on which expert is quoting what study, 70 to 85 percent of women who get breast cancer have no known risk factors. Only 5 percent of all breast cancers are inherited.

"This isn't 'high risk,' " says Barbara Balaban, who is director of the Breast Cancer Hot Line and Support Program at the Adelphi University School of Social Work on Long Island and a member of the coalition's working board. "This is a risk. What are the ones we don't know about?"

Many scientists and even some breast cancer organizations say that such statistics are needlessly alarming to women, and statistics are always slippery.

Larry G. Kessler, for example, chief of the applied-research branch at the National Cancer Institute, confirms that mammograms spot cancers that have been in the breast for "some time," but he says the assumption that they have been

The New York Times, August 15, 1993

there eight years is not necessarily true, since some cancers grow faster than others.

It is true, he says, that overall mortality rates have remained the same, but have recently increased in women over 50 and decreased in women under 50. "Different cohorts, or groups of women born at different times, bring different risks of death with them," Kessler says. He suspects that a trend in giving birth at a later age is key. Diet, exposure to electric power lines ("If you want to believe that," he says) and early exposure to DDT in the food chain may also be factors, but Kessler carefully distances himself from these suggestions.

Kessler allows that the coalition is "close enough" when it estimates that 1.6 million women have the disease (his own figure is 1.5 million), but he questions whether there are 1 million undiagnosed cases of breast cancer. If all women who have not been screened with mammography were to be tested, he estimates that there would be "about 162,000" more cases found. The one million unknown cases cited by the coalition, "may be based on estimates of tumor growth times and other approaches," he says. "I cannot verify this number, and I believe you should be very careful about using it."

One especially arguable statistic is the oft-repeated assertion that "one in nine" women will get breast cancer. Most people take that to mean one in nine women anywhere -- at the grocery store, at a P.T.A. meeting. But the figure is based on a life expectancy of 85 years: if all women lived to be 85, one in nine could expect to have a diagnosis of breast cancer at some time.

"There's only one reason to use those numbers," says Elin Bank Greenberg, chairman of the Susan G. Komen Breast Cancer Foundation, headquartered in Dallas, a national breast cancer organization that is not part of the coalition, "and that is to frighten women." The reality, she says, is that "among women aged 50, one in 50 will get the disease; the rate increases with age, and the true risks are being female and getting older."

The dispute over how to read the numbers is distracting, in part because statistics change and are open to endless interpretation. "This is not a competitive issue," Greenberg says. "It is unacceptable that in the decade of the 90's, an estimated 1.5 million women will be diagnosed, and 500,000 will die."

The coalition wants the Federal Government to spend \$659 million for breast-cancer research in 1994. They want access to screening for all women, including the uninsured. In addition, the coalition wants a "comprehensive national strategy" on the issue, coordinated from the White House. "The problem now is that there are isolated pockets of people looking at breast cancer, and no one is talking to anyone else," says Fran Visco. "These turf battles are fought, and we lose."

To win "a place at the table" they are kicking off another signature-gathering campaign, this time for 2.6 million names. (While steadfastly pursuing its own agenda, the 10-year-old Komen Foundation, which runs dozens of "Race for the Cure" events each year, is pitching in to help collect the signatures.) And coalition members are training themselves as lobbyists, educators and publicists.

The New York Times, August 15, 1993

IN A SENSE, THE breast cancer movement began when prominent women -- coincidentally all of them figures in Republican Party politics -- went public with the disease: Shirley Temple Black in 1972, and even more influentially, the First Lady, Betty Ford, in 1974, followed by Happy Rockefeller, wife of the Vice President. The television reporter Betty Rollin also pushed the issue into the public consciousness with "First, You Cry," a best-selling book about her breast cancer in 1976. Until these women spoke out, breast cancer was barely mentionable, a disease that women saw as shameful and humiliating. It eroded a woman's sexual confidence and identity, and was an essential fact that her best friends often did not know.

In the late 1970's, support and information groups began to form tight, nurturing bonds between women who might otherwise never meet: rich and poor, white and black, gentile and Jewish, lesbians and straight women, Republicans and Democrats. Terrified of death and disfigurement, the women sought others who had been through the tough treatments and the long nights.

During the 1980's, AIDS activists showed how anger could be put to good use, and breast cancer groups started to stretch their agenda beyond coping to the idea of curing. Like homosexuals announcing their sexual orientation, women frequently describe the first time they tell friends about their cancer as "coming out."

Since 1980, some 194,000 people have died of AIDS and 450,000 have died of breast cancer. The difference, as the television commentator and breast cancer survivor Linda Ellerbee points out, is that AIDS is always fatal and "some of us survive."

In terms of strategy, the breast cancer activists are (so far) less confrontational than some AIDS activists about their right to more medical research. But they also know that being nice often gets you nowhere, and that outrageousness works well in the political arena. Betsy Lambert, a Manhattan lawyer and board member of the national coalition, says "you've got to admire" the people who make an uproar. Lambert says she has had moments when she wants to be outrageous, perhaps even pelt indifferent bureaucrats with breast prostheses.

Activists like Matuschka -- a tall, striking artist in New York -- set out to shock. As a member of a small group called WHAM (Women's Health Action and Mobilization), Matuschka makes art of her mastectomy with poster-size, one-breasted self-portraits that force people to see what cancer does. Though some of her mainstream sisters are discomforted by the graphic images, they admire her determination. As she says, "You can't look away anymore."

More commonly, activists have taken the orderly route of lobbying, collecting signatures, working the system, confident that they can prevail by sheer numbers.

Certainly, one thing the movement has going for it is timing -- noisy 1960's activists who are in their 40's and 50's and baby boomers who were nursed on 60's activism are increasingly at risk for breast cancer. They understand the power of group politics. "I wasn't a famous activist, but I protested the war in the 60's," says Visco, the breast cancer coalition's president. "I spoke out for women's rights in the '70's."

The New York Times, August 15, 1993

In 1990, the publication of "Dr. Susan Love's Breast Book," a comprehensive and widely respected work co-written with Karen Lindsey, brought Love into the public eye. She is an engagingly direct and human surgeon who can laugh about her daughter's Barbie doll or fuss over not having had time to change from a blue suit rumpled on the red-eye from Los Angeles. Speaking before 500 coalition members in Washington, she drew a roar of laughter with a comment on the breast-squeezing mammogram apparatus that so many women hate: "It was indeed invented by a man, and I think there's a good tool we could invent for them with a little of our money."

In December 1990, Love met with Susan Hester, a Washington fund-raiser and director of the Mary-Helen Mautner Project for Lesbians With Cancer, to discuss formation of a national lobby. They called Amy S. Langer, executive director of the National Alliance of Breast Cancer Organizations, and the three set up the coalition in skeletal form. Within a year there were 150 member groups, then 180, and it's still growing.

One of the most active groups in the coalition is 1 in 9. The Northeast in general has a high rate of breast cancer, and Long Island's rate is especially high. According to one set of statistics, in the 1980's there were 94.7 cases of breast cancer for every 100,000 women; in Nassau County on Long Island, the rate was 110.6 cases. For years there has been talk of scattered cancer clusters on Long Island -- not just for breast cancer but all forms of the disease.

What would eventually become 1 in 9 began in 1987, after Francine Kritchek, a petite blond grandmother and teacher, had a mastectomy; Marie Quinn, a friend from work, admitted what she had told no one before: she, too, had breast cancer. The next year, Kritchek and Quinn sent a letter about the disease to everyone in their school.

But what really got them going was a state study of Long Island's breast cancer that found a relationship between high breast cancer incidence and high levels of household income. The study deemed environmental factors negligible, and said no further studies were warranted.

Women all over Long Island were outraged by the state's conclusions, among them Kritchek and Quinn, who later died of her cancer. They contacted Balaban at Adelphi, put a small ad in the local paper and sent a mailing to hundreds of people announcing a meeting. "Fifty-seven angry, frustrated women showed up," Kritchek says. Soon 1 in 9 was making local headlines, most notably with a protest by 300 women, some in wheelchairs, in front of the courthouse in Nassau County.

"The AIDS activists were our model," Kritchek says. "They showed that if the populace became very concerned, then the politicians would respond."

Under pressure from 1 in 9, the Breast Cancer Support Program and Senator Alfonse M. D'Amato, the Federal Centers for Disease Control held a public hearing on the need for another study. Members of 1 in 9 and others testified about suspected environmental risk factors, like auto emissions, polluted water, toxic wastes, pesticides and electromagnetic fields.

"Six months later they said the earlier study was sufficient!" Kritchek snorts. Rejecting the conclusions of the C.D.C report, 1 in 9 held a news conference with Senator D'Amato in January on "discrepancies," "archaic

The New York Times, August 15, 1993

thinking" and "patronizing implications" in the report.

The group also pledged to organize a study of its own in November, led by two breast cancer researchers, Susan Love and Dr. Devra Lee Davis of the National Academy of Sciences. Other groups, meanwhile, are distributing and tabulating questionnaires to identify possible clusters in Huntington, West Islip and Long Beach.

ACTIVISTS FOR the National Breast Cancer Coalition say they want a cure. But is money -- even unlimited Federal funding -- the answer? The millions of dollars allocated and used for AIDS research has not yet produced promising results. The Komen Foundation gives grant money to post-doctoral researchers in many different areas because, says Greenberg, "a researcher working on prostate cancer may find a benefit that has a splash effect on breast cancer."

Amy Langer, now vice president of the coalition, says there is a dearth of basic information on the breast. "Because so little is known about what's normal, about why cancer cells react the way they do and how we can control them," she says, "research is vital." For example, Langer says, technicians have had what she diplomatically calls "limited" success in working with human breast cancer cells in vitro. And there are issues like drug resistance on a cellular level: "Why does cancer stop responding to some chemotherapy, and why does chemotherapy knock out some cells but not all of them?" Langer asks.

Coalition leaders like Love think that money earmarked for breast cancer research can answer some of these questions, as well as throw light on how breast cancer starts.

"Basically, all cancer is genetic," says Love. "It's not all hereditary, but it's all genetic. What that means is, it's all a gene that screws up." Carcinogens, she says, interfere with normal genes. "What are these carcinogens in breast cancer? We don't have a clue. Could they be hormones? Sure. Could they be a virus? Sure." It could be pesticides, food additives or "a million" other things.

At the National Cancer Institute, Kessler is sympathetic to the movement's goals, but doubtful of its success. In his expert opinion, he says, "clinically, it's going to be impossible to detect" the first cellular changes that lead to breast cancer.

Love is undeterred. Scientists should look for the earliest mutations, and "maybe we can reverse the progress and development of breast cancer." The involvement of the Department of Defense in financing breast cancer research is fortunate, she believes, because it will spark productive competition between Federal agencies seeking a cure. Researchers go where the money is.

As the coalition's clout has grown, the powerful scientific and legislative communities that perhaps inevitably resist change have begun to hedge their objections to the advocates' assertions and demands. It's hard if not impossible to criticize mothers and sisters who are fighting cancer. Still, one challenge, generally voiced off the record, is that the coalition's determination to get more money for breast cancer will mean less money for other diseases. Critics squirm at the thought of "politicizing" medical research.

The New York Times, August 15, 1993

The coalition members describe this as backlash. "We don't want a bigger piece of the pie," they repeat again and again. "We want a bigger pie." They say research has always been political, because there has never been enough money for research. "Someone has been making the decision to fund 'X' at the expense of 'Y.' For too long those decisions have been made at the expense of women's lives," says Visco. "We've come along and we've said enough, stop; you have to start spending more of that money on breast cancer."

According to a story that Lesley Stahl of CBS News told at a charity lunch, Congress first saw breast cancer as a political matter in 1988, during the Reagan Administration, when Congressional women wanted Medicare to cover mammograms. It was a complicated issue, and the bill had to go through an all-male subcommittee. There were few breast cancer activists then, but a female lobbyist approached a congressman and asked him to introduce the necessary language in a larger health care bill.

His response personified Capitol Hill politics: "I did the women's thing last year," he said. "The guys will think I'm soft on women."

Her response was sexual politics: "Fear not. Just tell them you're a breast man."

Ultimately, the necessary language was inserted in the bill; the legislation passed, only to be lost when the entire catastrophic-health-care bill was repealed. But when George Bush became President, he needed the Congressional women's votes to pass his budget, and they again asked for mammogram coverage. The President agreed, but said he'd have to swap it for something else, Stahl says: funds for a children's program called Wee Tots.

In the last two years, since its collective consciousness was raised by Anita Hill's testimony at the Clarence Thomas hearings, Congress has learned to pay more respect to women's issues, including breast cancer. In part, this is because more and more lawmakers have personal experience with the disease. Senator Harkin, who championed the \$210 million in defense money for breast cancer, lost two sisters to the disease. Representative Nita Lowey, Democrat of New York, lost her mother and two aunts; she has sent a letter to President Clinton signed by 185 of her Capitol Hill colleagues endorsing the advocates' 1993 goals. Representatives Barbara Vucanovich, Republican of Nevada, and Marilyn Lloyd, Democrat of Tennessee, are themselves survivors and have made breast cancer issues part of their legislative proposals.

In the Senate, Patrick J. Leahy, Democrat of Vermont, arranged for the coalition to show its formal display, "The Faces of Breast Cancer," in the rotunda of the Russell Senate Office Building for a week. Although Senator Orrin G. Hatch, Republican of Utah, was one of the four who voted against Harkin's \$210 million Defense Department maneuver, he has since sponsored a bill requiring public health programs to provide clients with information about cervical and breast cancer.

"So what?" say some activists, implying that Hatch's response was trivial. But Lowey is encouraged. "You build support where you can get it," she says.

DURING THE WASHINGTON WORKSHOPS in May, in a session called "Identifying Opportunities for Influence," Sheila L. Swanson of the Bay Area Breast Cancer Network in San Jose, Calif., tells the audience: "We have to make it clear: We

The New York Times, August 15, 1993

may have had mastectomies, but we did not have a lobotomy." Her listeners cheer, and the next day several hundred of them buoyantly hurl themselves into the world of big-time lobbyists. Their inexperience sometimes can work for them; after all, these are voters first, lobbyists second. But other times inexperience leads to emotionally bruising confrontations.

In the office of Senator Daniel Patrick Moynihan, a dozen women believe they have an appointment with the Senator at 12:30 P.M. He is not there; an aide will speak with them. The meeting room is unavailable. Grumbling a little, the novice lobbyists -- some of them using canes because their cancer has spread to the spine, others pasty-faced from chemotherapy -- follow her to a dimly lighted basement lunch room full of workers grabbing a quick bite or smoke.

Scattered wrappers and bits of food litter the tables. Several women sweep the table tops clear before sitting. They push close to hear; the din from the vending and change-making machines is constant.

Yet they stick to their script: "As you sit here, every 12 minutes a woman dies." And: "What we're doing now probably will not save our lives. We're doing it for our daughters, and our sisters." They end, as instructed by workshop leaders, on a positive note, thanking the aide for the Senator's past support.

Afterward, in the hallway, Kritchek is furious. "Never in all my years have I been treated like this," she says. "It was insensitive, it was offensive." Brian Connolly, Moynihan's press secretary, later describes the way the meeting went as "unfortunate," but says the group had erred by not letting him know that journalists would be coming.

A few days later, at home in Hicksville, L.I., Kritchek is upbeat: giving interviews, making dinner, working the telephone and planning 1 in 9's next Walk-Run fund-raising event.

"Nothing will ever happen to breast cancer," she says, "unless it is politicized."

AS OF THIS WRITING, THE COALITION'S president, Fran Visco, has been named to President Clinton's cancer panel.

Long Island's 1 in 9 gave Fran Kritchek the first Marie Quinn Memorial Award.

Matuschka is making one-breasted self-portrait postcards.

Liz LoRusso is considering starting an experimental vaccination program for breast cancer in Chicago.

Sherry Kohlenberg, the woman who promised not to go silent into the dark night, met with Bill and Hillary Rodham Clinton in June. She died on July 14.

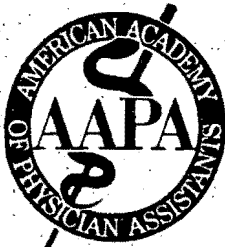
GRAPHIC: Photos: Strength in numbers: Members of the 1 in 9 Long Island Breast Cancer Action Coalition. Back row, from left: Louise Levine, Joan Flaumenbaum, Liz LoRusso, Joan Smihula, Serena Cummins. Middle row, from left: Karen Miller, Francine Kritchik, Yvonne Schmidt, Barbara Balaban. Front row: Geri Barish, Susan Kaplan. (Karen Kuehn/Matrix, for The New York Times) (pg. 24); Forcing people to see what cancer does: "Invasive Art," a plaster cast of the artist Matuschka's torso after her right breast was removed. Her poster-size

The New York Times, August 15, 1993

self-portraits have shocked even some of her mainstream sisters. They will soon be available on postcards. (Matuschka) ; Dr. Susan M. Love, director of the U.C.L.A. Breast Center, says early detection "is not early enough." (David Butow for The New York Times)(pg. 26); Fran Visco, president of the National Breast Cancer Coalition, and her son, David Visco Brandolph, 7. He was a year old when her breast cancer was diagnosed. (Stephen Shames/Matrix, for The New York Times); A rally in Boston sponsored by the Massachusetts Breast Cancer Coalition, October 1992. Congress has so far listened to the raised voices of breast cancer activists, to the tune of a \$300 million increase for research. (Marilyn Humphries/Impact Visuals)(pg. 27); Clara Piha undergoes mammography at Memorial Sloan-Kettering Cancer Center in New York. By the time cancer shows up on a mammogram, stray cancer cells could have already been ferried to vital organs. (pg. 58)(Photograph by Sara Krulwich/The New York Times)

LANGUAGE: ENGLISH

LOAD-DATE-MDC: August 15, 1993



American
Academy
of Physician
Assistants

950 North Washington Street
Alexandria, Virginia 22314

703-836-2272
FAX 703-684-1924

*Call to
set up*

February 18, 1994

First Lady Hillary Rodham Clinton
White House
Washington, DC 20500

Attn: Patty Solis
Director of Scheduling

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

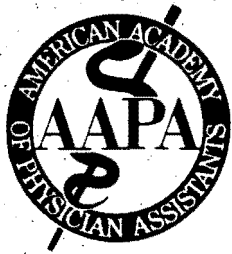
Dear Ms. Varveer:

*Liza 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 -
Doreen Hughes*

May

*Patti -
We need to
do a satellite
if we
don't go*

SM



American
Academy
of Physician
Assistants

950 North Washington Street
Alexandria, Virginia 22314

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

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)

to: Patty Solis
from: Steve Crane, AAPA
date: May 17, 1994
Page Two

I also thought 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)

to: Patty Solis
from: Steve Crane, AAPA
date: May 17, 1994
Page Three

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.

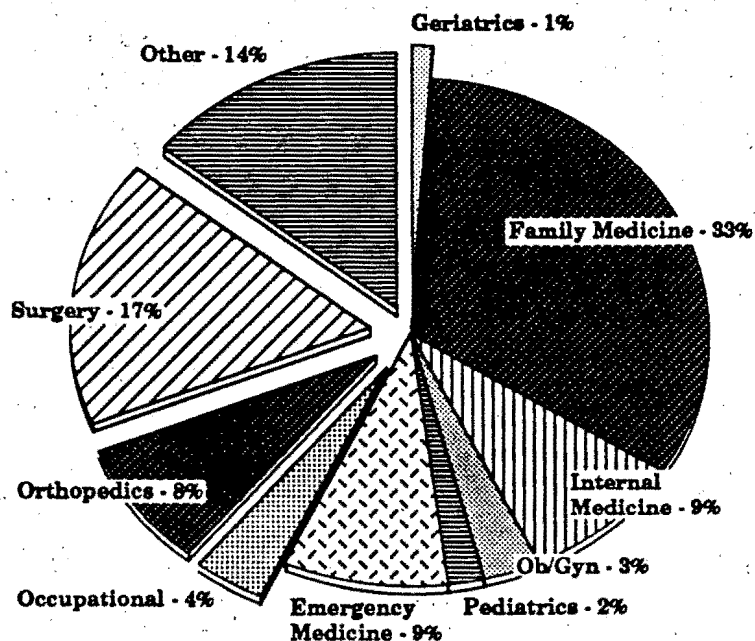
11 a.m. -- Reports from various PA leaders

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.

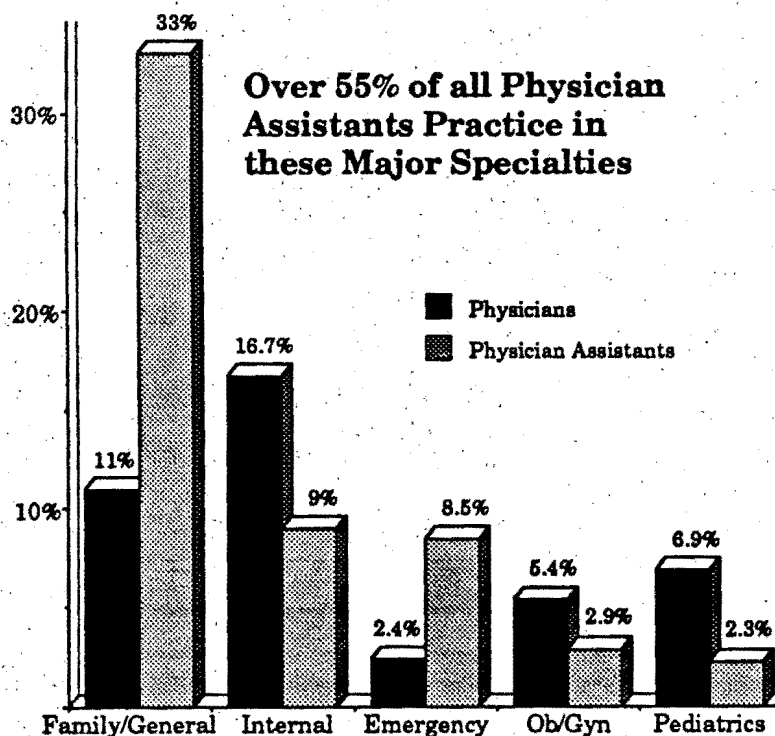
Physician Assistants: Partners in Medicine

- 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

- 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.

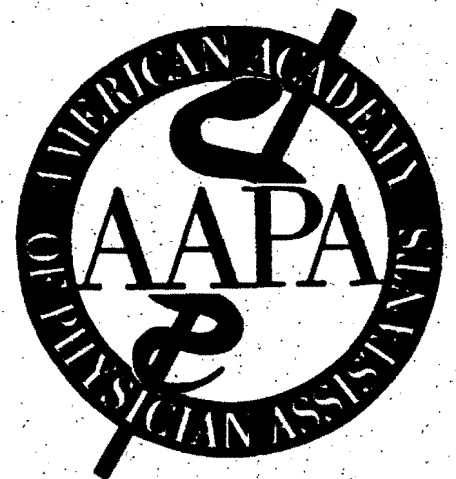


Source: Physician Characteristics and Distribution in the U.S., 1993, American Medical Association, and 1993 Census, American Academy of Physician Assistants (AAPA). AAPA includes emergency medicine when discussing primary care because of the large number of people relying on hospital emergency rooms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

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

AAPA

Physician Assistants:

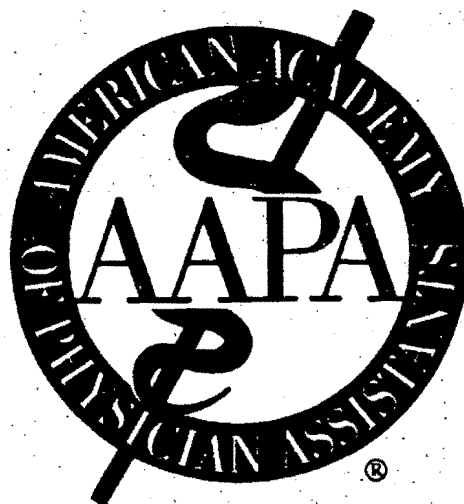


Partners in Medicine

PHYSICIAN ASSISTANTS

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
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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 perform 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

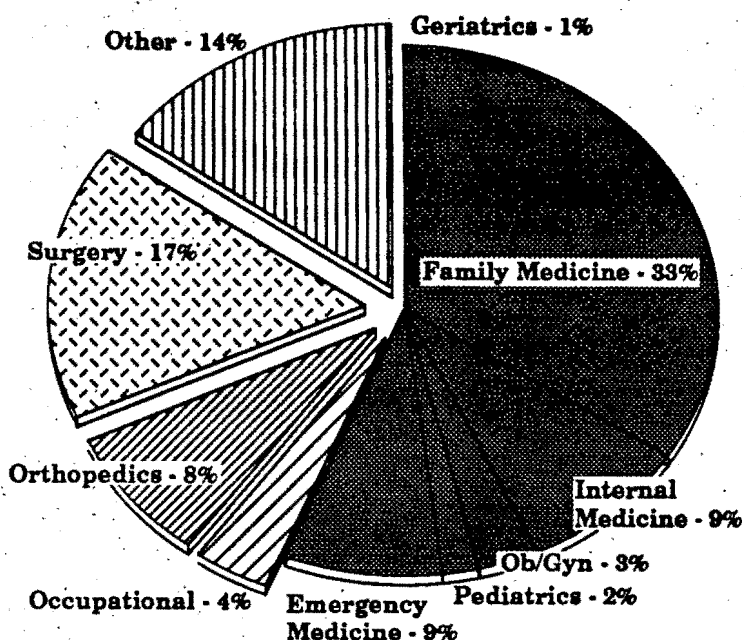
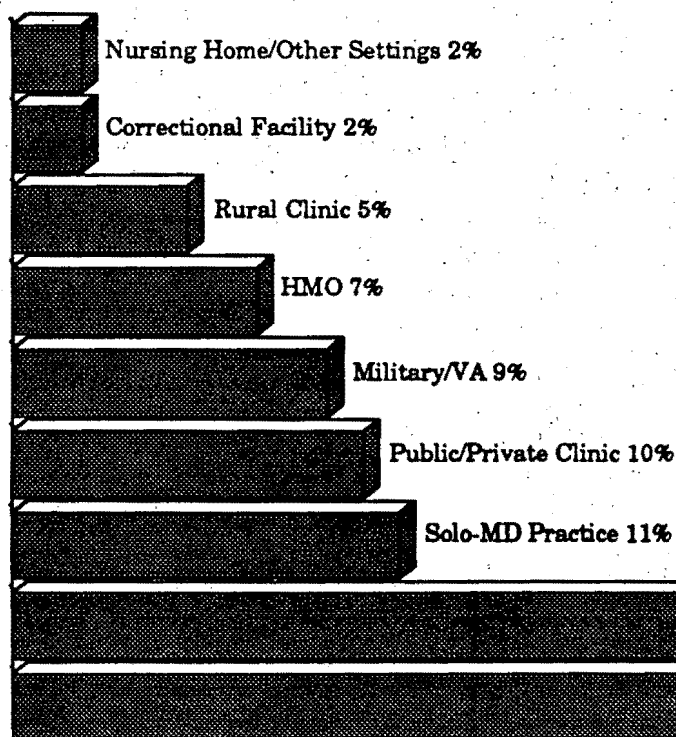
Physician assistants (PAs) practice medicine with the supervision of licensed physicians, providing patients with services ranging from primary medicine to very specialized surgical care.

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.

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



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

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

Classroom/Lab Instructions

Anatomy	Internal Medicine
Physiology	General Surgery
Pharmacology	Pediatrics
Clinical laboratory sciences	Psychiatry
Physical Diagnosis	Family Medicine
Microbiology	Behavioral Sciences
Pathophysiology	Emergency Medicine
Obstetrics/Gynecology	Biochemistry

Clinical Rotations

Emphasis is on Primary Care
Ambulatory Clinics
Physicians' Offices
Acute and Long-Term Care Facilities

National Certification Exam (Required in most states)

Continuing Medical Education (100 hours/2 year cycle)

Recertification Examination (Every 6 Years)

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.

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"(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.

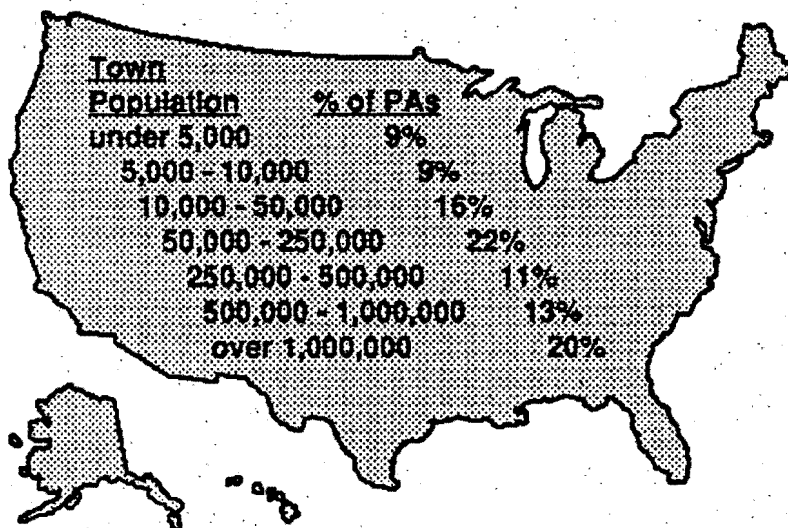
Prescribing

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.



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.

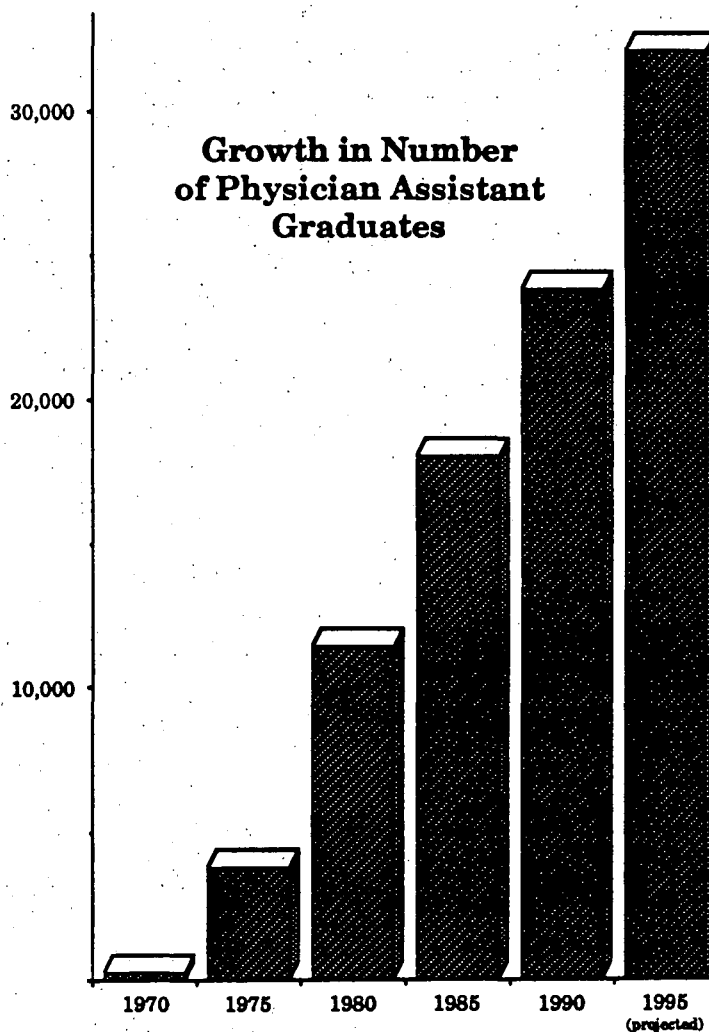
For more information, contact:
NCCPA
2845 Henderson Mill Road NE
Atlanta, GA 30341
(404) 493-9100.

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

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 1961⁶ 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 sub-

stantial 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}

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 pro-

grams' 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

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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, WV, 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 Program²³ 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	8.6	6.4
Surgical specialties	6.6	6.2	7.7	12.5	13.8	20.6
Medical specialties	3.9	6.3	2.7	4.8	7.1	8.0
Emergency medicine	1.3	4.9	4.5	8.4	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=8552	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.⁴³⁻⁴⁴ 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."^{44(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.⁴³ 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 *respondere 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 *respondere 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." ⁴⁷ (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.⁴⁹

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

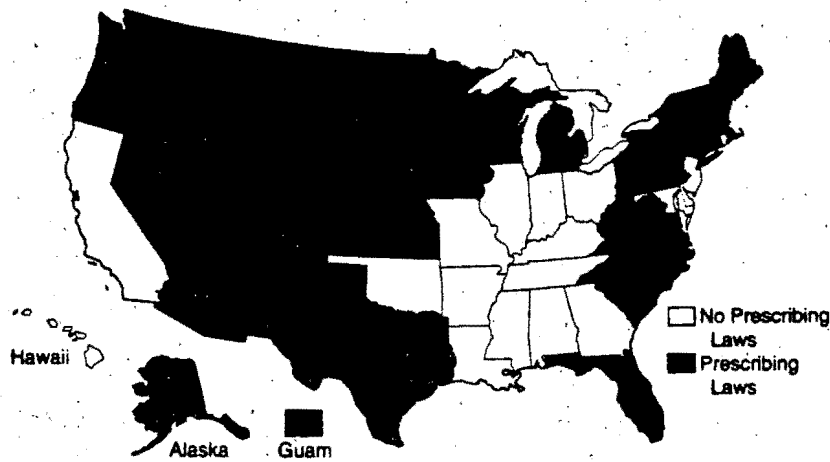
BARRIERS TO PA PRACTICE

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

PA's AND HEALTH SYSTEM REFORM



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 cri-

teria-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.

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,^{1,2,4,5,6,55} 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 pri-

mary 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

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 non-physician 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 24-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



TRIBUNE PHOTO BY NANCY STONE

"The quality-of-care studies that have been done are just wonderful for PA's. Malpractice claims are almost non-existent."

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.

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 medicals 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



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.

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.

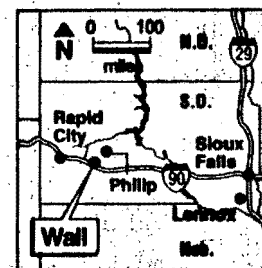
► More than 14% of rural residents go without insurance for at least a year; 18% of farm families lack insurance.

The South Dakota story is like others. About 100,000 residents, one-seventh of the population, go "bare" — without in-

surance. 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



USA TODAY

is offered every six weeks.

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 Mangulis, 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," Mangulis 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 Mangulis reduces his hours, 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 must 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 and 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 transplant coordinator at

'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

University Hospital.

"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



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.

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."

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 op-

portunities. 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

Please turn to Page 6

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



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

residents, nurses and doctors adapting to the three physician assistants working there under the pilot project.

"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 Reissner, 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, Thornton 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.

ProfessionallySpeaking

also ran July 7, 1993 in Allied Health
Section

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 prac-



Judge



Nelson



Patchin

Do APNs need doctor supervision?

NP, physician and PA face off

tice 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 com-

munity, or an affluent suburban community, or an inner-city ghetto.

. . . The best way to consistently 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 practitioner 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
Kaufold 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

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 entrepreneurship 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.