

# Physician Assistants

## Last Bastion of Primary Care—Or Will They Follow Physicians into Specialized Practice?

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**I**N THE MID-1960S, PHYSICIANS and educators recognized there was a shortage and uneven distribution of primary care physicians. To expand the delivery of quality medical care, Dr. Eugene Stead put together the first class of physician assistants (PAs) at Duke University Medical Center in 1965. He selected Navy corpsmen who received considerable medical training during their military service but who had no comparable civilian employment, basing the curriculum of the PA program in part on his knowledge of the fast-track training of doctors during World War II. Dr. Stead was also influenced by a rural North Carolina physician, Dr. Amos Johnson, who was an active leader in the North Carolina Medical Society and the American Medical Association. Dr. Johnson, a general practitioner, trained a man with no formal medical education to care for his patients when he was not available. Mr. Buddy Treadwell functioned in many ways as physician assistants do today, caring for patients in Dr. Johnson's absence, and consulting with and referring complex cases to Duke. The fact that he was African American in the segregated South makes it all the more remarkable. Today there are more than 50,000 PAs in the US; nearly 2,000 of them practice in North Carolina. Physician assistants are all trained as generalists, and fifty percent of PAs in North Carolina practice in primary care.<sup>1</sup>

Physician assistants are healthcare professionals licensed to practice medicine with physician supervision. As part of their comprehensive responsibilities, PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests,

counsel on preventive healthcare, assist in surgery, and—in most states, including North Carolina—can write prescriptions. Because of the close working relationships PAs have with physicians, PAs are educated in the medical model designed to complement physician training. What a physician assistant does varies with training, experience, and state law. In addition, the scope of the PA's practice corresponds to the supervising physician's practice. In general, a physician assistant will see many of the same types of patients as the physician. The cases handled by physicians are generally the more complicated medical cases or those cases that require care that is not a routine part of the PA's scope of work. Referral to the physician, or close consultation between the PA and physician, is done for unusual or hard to manage cases. Physician assistants are educated to know their limits and refer to physicians appropriately.

PAs are trained in intensive programs accredited by the Accreditation and Review Commission for the Physician Assistant (ARC-PA). There are more than 130 accredited PA programs in the nation, with four in North Carolina: East Carolina University, Methodist College, Wake Forest University, and Duke University. PA programs typically consist of a first year of classroom and laboratory study, and a second year of clinical rotations. The curriculum standards for PA education include basic medical sciences (anatomy, physiology, pathophysiology, and pharmacology); behavioral and social sciences; and ethics and health policy. Preclinical education includes instruction in eliciting patient histories, physical examination, laboratory medicine, and technical procedures. Instruction on the physician-PA team relationship is specifically required. Clinical experiences in family medicine, general internal medicine, pediatrics, prenatal care and gynecology, general surgery, emergency medicine, psychiatry/behavioral medicine, and geriatrics are required, and these experiences must be provided in ambulatory, emer

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gency, inpatient, and long term care settings. On average, PA students receive more than 2,000 hours of clinical training, under the direct supervision of physician preceptors.

Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of Physician Assistants (NCCPA) in conjunction with the National Board of Medical Examiners. Successful passage allows them to use the title "Physician Assistant – Certified," or PA-C. To maintain their certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every six years. Graduation from an accredited physician assistant program and passage of the national certifying exam are required for licensure in all states, including North Carolina. Physician assistants were one of the first health professions to require recertification by examination. The NCCPA is the only credentialing organization for physician assistants in the United States. Approximately 50,000 physician assistants nationally have been certified by NCCPA.

Physician assistants do not advocate or seek independent practice. In the early years of the PA profession, the vision of its physician leaders—Dr. Eugene Stead and Dr. E. Harvey Estes in North Carolina, and Dr. Richard Smith in Washington—was that PAs' scope of practice should be determined by the supervising physician. This concept of delegated or performance autonomy<sup>2</sup> has allowed physicians to extend their ability to care for patients in all settings.

Created to meet a need for access to primary care and trained as generalists, the majority of PAs have historically worked in primary care, often in rural and medically underserved communities. Competing needs may be changing this distribution, however. According to the American Academy of Physician Assistants (AAPA) 2002 census, 46% of PAs nationally are in primary care, down from 53% in 1998.<sup>3</sup> In North Carolina in 2002, 50% of PAs are in primary care specialties (family/general medicine, general internal medicine, general pediatrics, and obstetrics/gynecology). In 2002, 27.5% of North Carolina PAs practice in rural areas, with 5.3% in inner cities.<sup>4,5</sup>

Federal policy has encouraged PAs to practice in primary care, stimulating primary care education through Title VII, section 747, of the Public Health Service Act, which provides the only federal funding for PA education.<sup>6</sup> The program gives funding preference to those PA programs with the greatest numbers of graduates practicing in primary care and medically underserved areas.

Hooker and McCaig examined the use of PAs and nurse practitioners (NPs) in primary care through analysis of the 1995-1999 National Ambulatory Medical Care Surveys. While acknowledging that these data are limited to office-based practice and thus underestimate the activities of PAs and NPs in primary care, the authors assert that these clinicians provide care that is similar to physician care. They also noted that nonphysician providers often spend more

time with patients and order fewer tests.<sup>7</sup> Physicians in team practice with PAs and NPs usually handle the more complex cases, and in fact PA/NPs can free physicians to handle cases with greater acuity, which may account for differences in ordering of laboratory studies.

The primary care tenets of comprehensiveness, continuity, coordination, and community are acknowledged as valuable to the health of the nation, yet primary care is under great stress. The baby boomer "pig in the python" is nearing the age of Medicare eligibility, more patients are taking more prescription medications, and the overall case mix across the healthcare system is shifting from acute, episodic care to ongoing management of chronic disease. Primary care physicians are simultaneously beset with the need to reduce medical errors, perform well on HEDIS and other measures of quality, and see more complex patients while dealing with administrative aspects of practice, such as reimbursement and precertification. Cost patterns are measured by managed care profiling, and public report cards on individual physicians loom on the horizon. Where do PAs fit in this scenario?

Some suggest that primary care will become the exclusive province of nonphysician clinicians, after being abandoned entirely by physicians. Grumbach and Bodenheimer assert that this "new generation of primary care clinicians would struggle with the same irrationalities and dysfunctional systems that drove physicians from primary care practice," and note that future care models configured around multidisciplinary teams will require the strong and continued presence of physicians.<sup>8</sup> The commitment to practicing as part of a physician-directed team is clearly stated in the AAPA policy on team practice: "The AAPA believes that the physician-PA team relationship is fundamental to the PA profession and enhances the delivery of high-quality healthcare. As the structure of the healthcare system changes, it is critical that this essential relationship be preserved and strengthened."<sup>9</sup>

Ironically, at the very time that physician/PA team practice could be utilized to ease the burden on primary care physicians, health system and medical education changes are putting competing pressures on PAs' traditional commitment to primary care. While the number of PA graduates is increasing,<sup>10</sup> the number of PAs in primary care disciplines nationally has decreased from 53% in 1998 to 46% in 2002.<sup>3,4</sup> The same economic and lifestyle factors that may make primary care practice a less desirable choice for physicians<sup>11</sup> affect PA students as well. Although trained as generalists, PAs can practice in any specialty, and PA educators anecdotally note increased student interest in emergency medicine, urgent care, and the surgical subspecialties. Compounding this, the Accreditation Council for Graduate Medical Education (ACGME) is increasing enforcement of limitations on duty hours for residents. As academic health centers are faced with caring for the same number of patients through fewer available resident hours, many are hiring PAs to fill the

gap and maintain the “safety net” so vital to their communities. PAs are increasingly functioning as house staff, and there is burgeoning interest in PA residencies, especially in surgery and surgical subspecialties.

Born of a need for greater access to primary care, the majority of physician assistants have traditionally chosen primary care practice. Competing pressures and a declining pool of primary care providers raise questions for the future. A “primary care home” offers continuity, comprehensiveness, and coordination of care and can help patients learn to manage their chronic conditions and improve health outcomes. The Institute of Medicine’s report *Crossing the Quality Chasm: A New Health System for the 21st Century* suggested effective multidisciplinary teams were one solution to the problem of medical errors.<sup>12</sup> PAs are uniquely situated to contribute to these health system changes because of their training and socialization as team members. PAs, practicing in physician-led teams, are an important part of health system redesign, and can help meet the ongoing need for access to high quality primary healthcare.

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