日外会誌　116（3）: 201-204，2015

特別寄稿

Physician Assistants in the United States - Lessons Learned

President, Physician Assistant History Society of the United States

Alfred M. Sadler Jr.

Keyword are organized medicine, organized nursing, degree escalation, conflict between political parties, Ideal solutions

In the previous article on Physician Assistants in the United States, the focus was on the use of PAs in Surgery and the acceptance of PAs in the by Physicians in all branches of medical practice (reference—Journal of Japan Surgical Society). In this article, the focus will be on the resistance to the new Profession and related issues.

I. Support from Organized Medicine

In the United States, there has been very little organized resistance to the use of PAs by Physicians over the past nearly fifty years. No organized medical group or organization has ever officially voiced opposition. Rather the American Medical Association (AMA), the American College of Surgeons (ACS), the American College of Physicians (ACP) and others, have strongly supported the notion of non-physician team members working with them.

Because many American Physicians, while serving in the military services, had worked with battlefield medics (corpsmen), who were trained to deal with major and minor injuries and illnesses in World War II (1942-1945), the Korean War (1950-1953), and the Vietnam War (1967-1973), they were knowledgeable about the extraordinary contribution these individuals made. At the time of the first pilot PA Programs, the Physician leaders of the AMA and the leading specialty organizations were enlightened, flexible and willing to experiment with civilian use of non-physicians to help carry the burden of care to an expanding American population.

Of course, some individual civilian Physicians were skeptical at first, but nearly all of them revised their opinion, once they had the opportunity to work with PAs. Some patients were also skeptical in the beginning, but PAs proved themselves and acceptance has increased over the years. PAs are now fully assimilated into medical practice, in every state in the country.

As mentioned in the previous article, the practice of any health professional in the United States is regulated by each of the individual 50 states. Since the original amendments to state medical practice acts to allow PA practice were adopted in the early 1970s, most states have added legislation or regulations that affect what a PA can and cannot do.

These have covered such matters as remote supervision of PAs by a Physician in rural areas, where on site supervision is not possible ; allowing the PA to prescribe a full range of medicines ; and order tests and procedures, to name a few. The history of such legislative and administrative change has sometimes been contentious from state to state, but eventually matters have been resolved. In general, PAs scope of practice has expanded, as they have proved their worthiness and competence. They have moved into a variety of medical and surgical specialties.

II. Objections from Organized Nursing

Our greatest obstruction to the PA concept has come from organized Nursing, particularly among the Deans of certain Nursing Schools and among Nursing credentialing bodies. The often told story that illustrates this, dates back to the late 1950's at Duke University where Eugene A. Stead, MD and Thelma Ingles RN decided to train advanced practice nurses to

take on more traditional medical tasks and thus expand their scope of practice. This was at a time of increasing shortage of physicians, particularly in primary care and general practice. Dr. Stead was the innovative Chair of the Department of Medicine at the Duke Medical School and Ms. Ingles was Chair of the Department of Medical-Surgical Nursing at Duke's Nursing School. Before developing the Program, Ms. Ingles took a sabbatical year at Duke, working under the tutelage of Dr. Stead and his medical faculty, in order to learn additional clinical medicine. She was thrilled with the expanded knowledge and skills that she developed over that period. She and Dr. Stead moved ahead with an advanced program for nurses, who wished to take additional clinical training, just as Ms. Ingles had done. A curriculum was developed and a class of outstanding students was chosen.

Subsequently, after the first Duke class of advanced nurses (trained in large part by the medical school faculty) had successfully completed their Master's level course ; Ms. Ingles and Dr. Stead applied for accreditation of their program to the (NLN) National League for Nursing (the accrediting body for advanced nursing programs). They naturally believed that their pilot program would be greeted with enthusiasm by the accrediting body and expected that the program would be emulated elsewhere. They were shocked when the Program was turned down by the NLN on the grounds that there was too much physician involvement in the program and that it was not a "nursing" program. They were turned down a second time by the same accrediting body.

Subsequently, Ms. Ingles moved on to the Rockefeller Foundation and led a large number of successful nursing programs, particularly in developing countries. Meanwhile, Dr. Stead—convinced that non-physicians could play an important expanded role in health care in the United States, turned to former Military Corpsmen who were looking for jobs in the civilian sector. His first small class of what he termed Physician's Assistants entered a rigorous two-year training program in 1965. Three of the four graduated in October 1967, as the first formally trained PAs in the United States.

Soon thereafter, at the University of Washington School of Medicine, Richard A. Smith MD developed a Physician's Assistant Program, which he called MEDEX. His focus was on getting physicians into primary care settings in the rural communities of the Northwestern states. He established what he termed a "receptive framework" by going to the individual communities and selling the concept. He held "town meetings" in small towns that needed doctors and invited all the town's prominent people to attend. He told them of the value of non-physician providers in the Military and in other countries (Nigeria) where he had worked. Dr. Smith recruited Military Corpsmen for the first several classes of his Program. Over time, the components of Duke's, University based model and the community-based model at the University of Washington merged, to satisfy the requirements of the national PA Program Accrediting body. In so doing, both programs were enhanced, as was the new Profession more generally.

Returning to Nursing, there is little friction between most practicing nurse practitioners (NPs) and Physicians. In fact, they almost always have worked very well together. The problem still remains with some Nursing Deans and Nursing Regulatory bodies. This tension stems from the previous century, when some nurses (women) perceived themselves to be "hand maidens" to doctors (men) or hospital administrators (men).

With the success of the women's rights movement in this country, half of medical school (and law school) classes are now made up of women and the physician assistant profession has evolved from 70% men to 70% women. Nursing still remains 98% women.

Organized nursing decided in the 1960s to enhance its prestige, legitimacy and independence through the granting of degrees. They eliminated the traditional three-year, hospital based RN programs which produced excellent clinical nurses and granted a diploma in nursing, in favor of the two year Associate Degree RN program, whose graduates have less clinical skills but are on the academic ladder. They also developed Baccalaureate Nursing Programs, which produce RNs but contain very little additional clinical learning.

III. Moving toward advanced degrees

The Nurse Practitioner (NP) Programs have been at the Masters Degree Level with more clinical training, but based in Nursing Schools. The quality of the clinical skills of the graduates is dependent on the quality of the teaching they receive in their clinical rotations (frequently with physicians or physician staffed clinics). Their rapid growth was fueled by the success of the PA Programs, which on average deliver more clinical training than NP Programs do. More recently, Nursing Education Leaders have created a Doctor of Nursing Practice (DNP) degree and are closing down the successful Master's level NP programs. Their plan is to require all newly trained NPs to have the DNP degree.

Certain Nursing Deans have been quoted as saying that they want to take over the practice of primary care from physicians (who after all, prefer to specialize). There already has been considerable debate on this point and there will be more. Many physicians are not pleased with advanced nurses calling themselves "Doctor" while Nursing advocates of the new DNP degree argue that Physicians don't "own" the title "Doctor". It is useful to point out that three other US health professions ; namely Pharmacy, Physical Therapy and Occupational Therapy have all moved to the doctorate as the entry-level degree over the past decade.

They too, now call themselves "Doctor", albeit, not "Doctor of Medicine" or "Physician".

Meanwhile, because PAs have remained closely aligned with Physicians over the past five decades, they remain very much accepted by the Medical Profession. PA Educators and Practitioners held an historic "summit meeting" in Atlanta in 2009 to consider the issue of the Clinical Doctorate for PAs. The idea was voted down and the decision was made to continue PA Programs at the Masters Degree level—a decision that holds to the present day. The principles that prevailed were the same as those from the inception of the PA Profession. PAs would continue to be defined by their demonstrated competence. Insisting upon a clinical doctorate would simply increase the cost of education and add to confusion about roles. Many Faculty members of PA Programs obtain an appropriate Doctorate Degree in a related field, such as Public Health, Education or a research discipline. This will continue in the academic world but is not necessary or expected in clinical practice.

IV. Conflict between the political parties in the US

The biggest battle over health care in the United States has been between the two major political parties (Democrats and Republicans). Although the recently adopted (2010) and sometimes controversial "Affordable Care Act" has enfranchised more than ten million Americans who previously lacked access to health care, we are still are a long way from universal health coverage in the United States. PAs and NPs are both very popular professions and have a bright future as the Affordable Care Act is implemented in the various states. They are seen as important members of the health care teams who will help care for the additional millions of Americans who are covered under the law. An important argument in favor of producing PAs and NPs is that their education time and cost to train are considerably less than producing a fully trained physician.

The acceptance and recognition of PAs in this country was the result of carefully thought out educational models and the subsequent innovative national accreditation and certification processes as discussed in the previous article. Holding conferences, discussions and demonstrations were invaluable as was as research comparing the practice of PAs with medical students, interns and residents and House Staff.

Training PAs by Physicians and subsequently highly skilled PAs has the advantage of avoiding the entrenched beliefs among some Nursing leaders that they want to be "independent" from Physicians and therefore not "supervised" by them. This remains an evolving concept in the United States.

V. The ideal solution for workforce issues in any country

The solution to the workforce issues in any country must come first from the articulation on a common

purpose i.e. to provide the best possible care to all citizens at a reasonable cost. Next, it will be essential to get all the involved parties to meet and work out best alternatives. Included in the solution will be an examination of the best composition of physicians and non-physicians to meet the needs of patients.

Often experimentation is required and money and time must be set aside to evaluate pilot programs for training surgeon's assistants and practitioners for primary care and other disciplines. In the United States, this kind of experimentation and analysis has been going on for nearly fifty years. There have been many successes. Yet, there still are issues of professional boundaries such as scope of practice and degree of independence, as mentioned above. Human beings and human organizations will always see the world from their own and sometimes selfish point of view. We are no exception.

A sample of some of the other countries using PAs is included in the references below.

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Conflict of Interest

No potential conflict of interest was disclosed

