PAGE: Physician **A**ssistants **G**enerating **E**xcellence
Inaugural Journal of the India Association of Physician Assistants - 2015

Observations on U.S. Physician Assistant History

Ruth Ballweg MPA, PA-C

Background/Context

The origin of the US physician assistant movement can be viewed as the ultimate "problem solving" opportunity. As important components of President Lyndon Johnson's ' "Great Society" movement , the Civil Rights Law (1963) and the Medicare Law (1965) suddenly created health care access for millions of Americans. Simultaneously, the Viet Nam Conflict—the world's first "televised" war—brought
new visibility to the roles and skills of military medical personnel (corpsmen) in caring for both soldiers and civilians. In addition, the rising feminist movement was empowering U.S. nurses to consider new and expanded roles. The shortage and geographic mal-distribution of doctors made it possible to consider the creation of new health care roles to expand health care access and to increase efficiency. The result: Physician Assistants (PAs) and Nurse Practitioners (NPs) as innovations to improve the nation's health!

The story of PAs in the U.S. starts with physician "champions"—each of them innovative, persuasive, and willing to take a risk. These doctors—and the geographic locations served by "their" PA programs-- illustrate the flexibility and adaptability of the PA "concept." The Duke PA Program was developed by Dr. Eugene Stead in a large academic health center in North Carolina. Trained alongside medical students and residents, the new PAs were most likely to choose employment in similar settings. At the University of Washington School of Medicine, in Seattle, Dr. Richard Smith developed the MEDEX Program in collaboration with the Washington State Medical Association. MEDEX was designed to support isolated and overworked rural doctors and to fill primary care gaps in urban settings. The Child Health Associate Program, developed by Dr. Henry Silver at the
University of Colorado School of Medicine chose a wide-range of students—many from teaching or child advocacy backgrounds—to meet the health care needs of infants, children and adolescents. Silver's 3- year program offered the first PA masters degree. In West Virginia, Dr. Hu Myers built a 4 year bachelors degree program which recruited students directly from rural high schools for a model that provided health care to hard-to-reach communities. In Alabama, a cardiac surgeon, Dr. John Kirklin, created a program specifically to train PAs to work in surgery roles.
As the PA movement grew, new PA programs often modeled their curriculum design on one of these initial programs. By September 2015, there were 196 accredited PA programs in the U.S.

Historical Features of the U.S. PA Movement

While the stories of the initial five PA programs may seem to be simply "facts", they illustrate a number of important historical features of the U.S. PA movement.

1. Flexibility/Adaptability**:** The needs of patient populations, doctors, and health care systems differ from region to region and state to state. While people refer to the "U.S. health care system"—there really is no overarching national or unified health care delivery system which consistently serves the U.S. population. Even federally funded health care structures such as the Veterans Administration or Community

Health Centers, must still "fit " into local community settings in order to operate effectively. This is also the case in many of the countries where the development of PAs is being considered as a strategy to provide and expand health care. There may be a wide range of health care needs and different health care structures in different countries and states. Fortunately, the flexibility of the PA role makes it adaptable to meet national, regional, or even population-specific needs.

2. Physician Champions**:** Relationships between supervising doctors and physician assistants are critical to our identity and our role. The "physician/doctor" champions who created the first PA programs also led the way in demonstrating the role and relationships through strong ties with organized medicine at all levels. While PAs are now regulated in every state in the U.S. , the optimum laws are in states, and clinical practice settings where doctors are strong supporters of PAs.

In the U.S .there is the aspiration for "autonomy" by nurse practitioners and some PAs who believe that freedom from physician "control" will be in their best interest. In their arguments, they incorrectly imply that that NPs are "autonomous" throughout the U.S. and that large numbers of PAs support the autonomy movement. In reality, nurse practitioner autonomy varies from state to state and even then, they are subject to the authority of "medical directors" of the services on which they are employed. Most U.S. PAs value their relationships with their supervising doctors regardless of how often they consult them. In many settings, "autonomous" nurse practitioners have much narrower scopes of practice as compared to PAs whose relationship with a physician generally brings with it a broader scope of practice based doctor/physician assistant relationships

3. Choosing the "right" students**:** A key to the success of PAs historically has been the recruitment, selection and deployment of individuals who are "trainable" and willing to take the risk of pioneering a new career. It's not just "anybody" who would be willing to invest the time, money, and the support of their family in what may have seen as a unproven and uncertain career. The fact that the PA "concept" even suggested that people with less education than doctors would be allowed to do "doctor-like" tasks, was unthinkable—but also fascinating!

The success of PA programs depended on their first classes.. Students had to be flexible. They had to be smart. They had to be willing to be in the public eye. They had to be able to get along with everyone—including those who didn't support them. They had to be willing to be the role models for all who followed in their paths. It was a tough job and PA programs devised s unique recruitment and admissions interview models in order to choose the pioneering students.

4. New Educational Models: PA programs were never designed to be "mini-medical schools." Instead they most often used "competency based" theories best utilized with "hands-on" adult learners. These techniques were built on a process of deciding what skills would be needed by these new clinicians and then working backward from that point to develop integrated "need to know" content which was guided by specific objectives, frequent assessments, and experiential processes. Required attendance became a standard feature of PA programs where the accelerated program content moved quickly and was not repeated.

5. PAs as Advocates and Leaders: From the beginning, physician "champions", the PAs, and PA faculty members recognized the need for organizations to advocate for the new profession and move it forward. While initially developed at the "program level" and promoting individual program models, these individual organizations were brought together to form the American Academy of Physician Assistants (AAPA) which—despite some initial conflict and disagreement—finally recognized graduates from all of the programs. Individual PAs constitute the membership of the AAPA.
The Association of Physician Assistant Programs (APAP) -- later renamed the Physician Assistant Education Association—was created to share resources, advocate for federal funding, and to serve as a network for PA faculty members. Membership in PAEA is composed of PA programs rather than individuals. The Accreditation process for PA educational programs is managed by what is now called the Accreditation Review Commission on the Education of Physician Assistants (ARC-PA). The ARC-PA "protects the interests of the public and physician assistant profession by defining the standards for physician assistant education and evaluating physician assistant educational programs within the territorial United States to ensure their compliance with those standards. " Finally, the National Commission on Certification of Physician Assistants (NCCPA) serves as the only certifying organization for U.S. physician assistants, providing certification exams, and recertification processes for physicians assistants.

These four organizations serve as a strong "4-legged stool" to promote and protect the PA profession. Notably, leaders of these "4-orgs" meet together regularly keep each other up to date on recent developments and to collaborate on issues of advocacy.

6. Recognition and Regulations: As PA programs were developing, it was important to create laws and regulations that would allow PAs to practice medicine. In the U.S., regulatory processes are created and managed at the state level, rather than nationally. This allows individual states to customize policies to fit their environments and meet the needs of their citizens. Developing PA state practice laws took longer than most people realize, with some states recognizing PAs in 1971 and the last state, Mississippi, delaying this decision until 2000!

Over time, state PA regulations have been updated and upgraded to reflect the expanded roles of PAs in every medical specialty and in many types of clinical settings. At a minimum, PA licensure in every U.S. state requires graduation from an accredited PA program, successful completion of the NCCPA national certifying exam, and documentation of the supervisory relationship between the doctor and the PA.

At the employment level, PAs are governed by the same credentialing processes that also oversee doctors in a hospital or health care system.
These credentialing processes include documentation of training, licensure, and experience, as well as "check-off" task lists that are approved individually for each clinician. As with state laws, credentialing processes

for PAs in health care systems have expanded PA scope of practice expand access and efficiency and also to maximize the utilization of new technologies.

7. Getting Paid for What We Do: A new health care profession could not survive payment for their services. There was no easy solution to this quandary. Here again, the practices varied from state to state, from one insurance company to another, and across governmental agencies.
In some areas, PAs were initially reimbursed at the same rate as doctors.
In other areas, they were not reimbursed at all. Procedural specialties sometimes "bundled" the PA fee in with other services provided by the doctor's practice.
Opponents of PAs used reimbursement strategies to slow our development.
Proponents of PAs were willing to say that PAs should be paid less……but not a lot less. Finally the US government led the way and in 1995 after a hard-fought battle--in which PAs and NPs joined together as unified force--Medicare (the federal program for the elderly) agreed to reimburse PAs and NPs equally at 85% of physician rates. This rate did not require direct physician involvement in the patient encounter. Since 1995, no other categories of health professionals have Medicare achieved reimbursement for their care.

Moving into the Future:

As the PA profession continues to grow, some overarching issues and concerns deserve our attention. One of our most important goals is that the PA profession continue to "speak with one voice." While we may have internal disagreements, the collaborative relationship between the four PA organizations
(AAPA, PAEA, ARC-PA, NCCPA) is key to our long-term success.

An on-going concern has always been: "are we growing too fast?" This concern centers on whether PA programs are created in appropriate and supportive institutions, whether there are a sufficient number of clinical training sites, and whether there are enough PAs who can be recruited as faculty members to develop, implement and maintain the programs.

As the "first generations" of PAs move into retirement, we also wonder what impact these retirements will have on the profession. We are also curious to learn about the choices that these PAs make about their retirement life styles and whether they define new types of service utilizing their background and experience.

Overall, we're concerned about "growing" PA leaders, PA scholars and PA advocates who will continue to maximize the PA profession's contribution to our nation's health. That has been our history—and we feel strongly that we must stay on that path.

Note: The observations and opinions expressed in this paper are those of the author and do not necessarily reflect the views and/or policies of the organizations or institutions with which she is involved.