The Roots of the AAPA

The AAPA's first president remembers the milestones and accomplishments of the Academy's first decade.

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Because of the criticisms directed at their chosen profession and the absence of educational criteria essential for greater employment opportunities within the health care system, the first students and graduates of PA programs banded together under the umbrella of the American Academy of Physician Assistants (AAPA). Soon after the AAPA's incorporation in 1968, its leaders found themselves embroiled in discussions dealing with occupational nomenclature, practitioner education, and competency assurance, all of which resulted from involvement in the processes of program accreditation and graduate certification. During these discussions among themselves and with their advisors, the leaders set the stage for an organizational infrastructure that would encompass a House of Delegates, constituent chapters, committees, strategic planning, and liaison activities with other organizations. The subsequent establishment of a national office with an employed staff allowed for a more proactive stance on issues, particularly Medicare reimbursement. Long-range management also provided the financial reserves needed in future years to construct a lasting monument to the profession, the national AAPA office in Alexandria, Virginia. (J AM ACAD PHYS ASSIST 1992;5:671-8.)

During the period of economic prosperity after World War II, Americans began to change their attitudes toward health care. Medical knowledge acquired before and during the war had vastly changed medicine, and Americans began to see health care services as an entitlement. Beginning in 1950, this demand steadily increased; by 1965, expenditures for health care were $40 billion or 13.3% of the gross national product. The reasons for this unparalleled growth were many: Americans were earning higher incomes and more of them were enrolled in health insurance plans; people were living longer and with this came higher rates of chronic diseases; and, finally, the federal government had more money to spend on needed health care services.[1]

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Compounding these sociocultural pressures were the changes occurring in the physician marketplace. In addition to an upsurge in specialization,[2] many physicians were becoming involved in full-time academic careers and research. This contributed to growing concerns throughout the country that the population's needs for health care were not being met. Intensifying anxiety and dire predictions by economists, politicians, and health professionals set the stage for the birth of a new health profession, the PA profession, but it was not an easy birth.

ANTIPATHY AND AMBIVALENCE

In the late 1960s, when the PA profession was introduced, nurses were expected to stand and surrender their chairs to doctors who walked into the nurses' station. Many medical libraries at that time still would not lend books to medical personnel who were not physicians. On becoming civilians, highly trained and experienced medical corpsmen, who had independently administered life-saving medical treatment on the battlefield or had worked in military hospitals, were offered less than minimum wage positions as

hospital orderlies or housekeepers. In addition, in certain areas of the United States, hospitals were racially segregated and so were their medical staffs. Those persons who challenged the existing sociomedical conditions were quickly reminded of their proper places.

As the new profession took its first shaky steps into the world, PAs encountered antipathy and skepticism, as well as support. As late as 1973, the deputy assistant secretary of the Department of Health, Education and Welfare, George Silver, stated that "the doctor shortage is no excuse for second class care by non-MDs."[3] AMA President Charles Hoffman told a legislative committee that human life was too important to relegate to a health professional who was not as well trained as a physician.

That a new medical profession could be conceived and developed in this conservative and tradition-bound community is a tribute to the pioneering spirit and unconquerable optimism of the early generation of PAs and their ardent supporters. Not only were the original PA program and its variants replicated many times during the ensuing years, but the laws governing the practice of medicine were changed, standards to accredit PA programs and certify practitioner competence were devised, and major legislation encouraging broader use and reimbursement of nonphysician practitioners was enacted.

■ AN OPPORTUNITY GREATER THAN THE RISKS

The concept of formally training a group of medical corpsman as PAs began relatively quietly as a response to local pressures and problems at Duke University Medical Center. Perhaps this quiet birth allowed the new profession to gain strength before exposure to public scrutiny and was, in part, the reason for the profession's success.

In 1964, a committee chaired by Andrew Wallace was charged by the chairman of Duke's Department of Medicine, Eugene A. Stead, to find solutions to the chronic staffing shortages confronting some of the evolving, technologically intensive specialty areas within the institution. These areas included the cardiac catheterization laboratory, the kidney dialysis unit, and the hyperbaric chambers. At that time, many of the attending physicians at the medical center were consultants to major military facilities and knew that within the military similar units were staffed by corpsmen. The Wallace committee suggested that the medical center could easily add to the training and experience of ex-corpsmen.

Stead, who had previously trained a small group of nurses in these functions, knew that nonphysicians could learn to perform tasks that were then solely in the domain of physicians, and he accepted the ideas of the Wallace report. The first program to formally train assistants to physicians began in October 1965 with four trainees, all of whom had been navy corpsmen.

Trainees in the first three classes at Duke were exclusively recruited from the corpsmen pool. As corpsmen, these men wanted to make medicine their life's work, yet because of age, family, finances, or premilitary academic performance, the option of medical school was not realistic. The only other viable options for medical careers were nursing school or medical sales.

Those who competed for the limited positions in the early classes for PAs did so realizing that they would most likely have to stay in North Carolina and at Duke because existing state laws did not support PAs and because the national medical community was generally opposed to the new profession. PA students and graduates were particularly sensitive to legal issues because of California's landmark case of *Shasta County v. Whittaker (1966)*,[4] in which an ex-navy corpsman was found guilty of the unauthorized practice of medicine. This decision raised the possibility that existing medical practice acts allowing delegation under direct supervision might not include PAs unless statutory changes were made. Because of this uncertainty surrounding their legal status, the members of the first PA class remained at the Duke University Medical Center after graduating in 1967.

■ UNITED WE STAND

The winter and spring of 1968 brought optimism to the students in the second and third classes of the Duke program. A rumor rippled through the small community that Dick Scheele, a graduate of the first class, would be leaving Duke to join a private practice in the community. This news, coupled with the increasing awareness that national interest in the PA profession existed, nurtured hope that opportunities for employment outside the Duke community or in other states would emerge. During an informal meeting in a small basement office of the medical center, conversations concerning Scheele's departure quickly led to the recognition that PAs needed to begin the process of nurturing employment opportunities through a professional organization. These were the first steps taken to create what was then known as the American Association of Physician Assistants (AAPA).

E. Harvey Estes, Jr., chairman of Community Medicine and director of the Physician Assistant

Program at Duke, offered to become the new professional association's advisor. He made arrangements with a professor at the law school to guide the students through the process of incorporation in North Carolina and also lent $700 to pay for incorporation fees. The original purposes of incorporation—to educate the public about PAs, to provide education for PAs, and to encourage service to patients and the medical community—remain valid cornerstones of the AAPA today. The AAPA was incorporated in North Carolina in 1968.

The first meetings of the AAPA, between 1968 and 1969, concentrated on housekeeping details common to all fledgling organizations, such as bylaws, election of officers, and the creation of dues. Once a structure was in place, the association meetings organized educational activities to address subjects not covered in program curricula, arranged for an advisor from the North Carolina Medical Society, explored a benefits package for members, and contacted colleagues at two newly founded programs, the MEDEX Program at the University of Washington in Seattle and the PA Program at Alderson-Broaddus College in Phillipi, West Virginia.

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The new professional organization also established the AAPA newsletter as a means of communicating with members and with others on behalf of the profession. Two years later, in April 1971, a journal, titled *Physician's Associate*, replaced the newsletter as the official publication of the AAPA. Russell Lawrence, PA-C, was its first editor. The purpose of the journal, which later became the JOURNAL OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, was to promote research, provide continuing education, and serve as a forum for AAPA business.

The formative meetings also involved discussions concerning the need for guidelines for directing emerging educational programs for students, the position of PAs within the existing legal framework for health care, and the need to establish criteria to determine continued quality of performance by PAs.[5]

Leaders of the AAPA attended the January 1969 meeting of the Committee on the Physician's Assistant, which was sponsored by the AMA Council of Health Manpower and charged with the goal of "making recommendations on the training, supervision, certification, and role of physician's assistants."[6] During this meeting, as president of the AAPA, I requested "formal recognition and guidance" from organized medicine and the "opportunity [for the AAPA] to be involved" in defining the role of the PA. I also asked for their support for the formation of a "national registry with periodic examinations" to stimulate continuing education within the profession.[7]

EARLY AAPA DIRECTIONS

The first annual AAPA meeting was held in June 1969 and was attended by 60 members, most of whom were students. Also present at the first meeting were advisors from the state medical society, academic medicine, and private practice, who suggested ways to develop the association that would maximize growth and minimize the risk that PAs would be regarded as interlopers in the medical community. The newly elected board established four goals at the first meeting; these goals dealt with the issues of refining the infrastructure of the AAPA, the importance of fundraising, the necessity of developing good public relations, and the establishment and conduct of board meetings and annual meetings.

As the AAPA began its second year, its leaders read with great interest the number of articles appearing in professional and lay publications reflecting a national interest in the profession. Particularly noteworthy was an article in the *Journal of the American Medical Association* that published the results of a survey conducted in Wisconsin; 61% of physicians who responded to the authors' questionnaire indicated they needed a "doctor's assistant" in their practices.[8] These encouraging results, coupled with the increasing number of PA programs that were operating or developing throughout the country, caused a shift in the focus of the AAPA to how PAs would be diffused nationally and what would be acceptable avenues of training for this emerging profession. The AAPA began a dialogue with the American Medical Association (AMA), asking for formal recognition of the association and profession and for suggestions on defining the PA role and standardizing the training programs.

Because by 1969 three discrete PA training models had developed—the medical school based curriculum (Duke model), the apprentice-based MEDEX program, and the specialty-based Child Health Associate program—the AAPA's major challenge was to develop a policy on criteria for membership. A commit-

PRESIDENTS OF THE AAPA

Year	President
1968-69	William D. Stanhope
1969-70	William D. Stanhope
1970-71	John J. McQueary
1971-72	Thomas R. Godkins
1972-73	John A. Braun
1973-74	Paul F. Moson
1974-75	C. Emil Fasser
1975-76	Thomas R. Godkins
1976-77	Roger G. Whittaker
1977-78	Dan Fox
1978-79	James E. Konopa
1979-80	Ron Rosenberg
1980-81	C. Emil Fasser
1981-82	Jarrett M. Wise
1982-83	Ron L. Fisher
1983-84	Charles G. Huntington
1984-85	Judith B. Willis
1985-86	Glen E. Combs
1986-87	R. Scott Chavez
1987-88	Ron Nelson
1988-89	Marshall F. Sinback, Jr.
1989-90	Paul Lombardo
1990-91	Bruce C. Fichandler
1991-92	Sherri L. Stuart
1992-93	William H. Marquardt

tee was organized to consider the development of state societies and student chapters and to modify the bylaws to include students as full voting members of the board. After the appointment of three Duke PAs to the staff at Alderson-Broaddus College, the first regional chapter of the AAPA was chartered in 1970, a sign that the AAPA was becoming a national organization.

By the November 1970 annual meeting, the AAPA had established the following additional goals for the incoming president and the board of directors: attain tax-exempt status, establish the office of president elect, develop and project a budget, expand public relations, develop staggered terms of office for the board, and create a liaison with the American Registry of Physician Associates. The latter had been formed in June by the directorates of the PA programs at Duke University, Bowman Gray School of Medicine (Wake Forest University), and Alderson-Broaddus College after unsuccessful attempts to encourage the AMA to assume a leadership role in the standardization of educational programs and the recognition of practitioner performance. The purpose of the American Registry of Physician Associates was to test the competence of PAs from the medical school programs and to certify the results.

The end of 1970 marked a pivotal change in the AMA's wait-and-see attitude regarding PAs. Earlier in the year, Paul Sanazaro, director of the Department of Health, Education and Welfare's National Center for Health Services Research and Development, addressed the AMA and suggested a 5-year effort to determine the feasibility of using nonphysicians to perform functions reserved for the physician.[9] In addition, the AMA was confronted with the realization that the air force was planning to establish a PA training program that would begin in the summer of the next year.[10]

By September 1970, Ralph Kuhli, director of AMA's Department of Allied Medical Professions and Services, wrote: "The physician's assistant catches on like an idea whose time has come. We in the AMA must do something about it."[11] This clarion call would lead to meetings between representatives from the AMA's Council on Medical Education and the National Advisory Council on Health Manpower and between leaders of the AAPA and directors of PA programs.

Unfortunately, the close of 1970 also marked the great loss of one of the AAPA's founding members, Richard Scheele, a member of the first PA class at Duke University Medical Center and incoming president of the organization. He died at the age of 29 from an acute myocardial infarction. John McQueary, a charter member of the AAPA who had shared an office with Scheele at Duke, became president (see Box).

Between November 1970 and November 1971, under McQueary's leadership, the PA profession and the association experienced a great transformation. New programs observing the Duke model and the MEDEX model were instituted, and students at these programs were contacted for membership in the AAPA. The AAPA's board of directors was expanded to allow student members to be elected to the board with full voting privileges.

NOMENCLATURE AND EDUCATION

The proliferation of PA programs and the varying criteria for admission into and graduation from these programs created a major challenge for the AAPA during the 1970 to 1971 period. In addition, large numbers of informally trained medical personnel who had been performing some PA-type functions announced themselves to be PAs. By the end of 1970,

more than 125 programs in 35 states announced that they were training "physician support personnel."[12] Adding to the confusion was the sudden emergence of three other organizations that professed to represent PAs.

Nomenclature for the Different Types of PA Programs

Stepping into the fray in an attempt to create order out of pending chaos, the National Academy of Sciences developed and, in 1970, publicized a nomenclature for PA programs in which "Type A" referred to the Duke medical school–based model, "Type B" referred to the Child Health Associate (CHA) specialty-based program, and "Type C" to the MEDEX apprentice-based program.[13] The National Academy of Sciences report referred to graduates of Type A programs as "physician's associates." Membership in the AAPA was then restricted to students and graduates of 2-year Type A programs.

The name of the professional organization was subsequently changed to the American Academy of Physician Associates in an attempt to distinguish its members from those of other educational or training models. The AMA House of Delegates stood in opposition to the term "associate" because it implied a level of professional collegiality inappropriate to a person functioning as an assistant to a physician.[14]

AAPA Becomes Involved in the Process of Accreditation

The existence of three other groups claiming to represent PAs and the confusion surrounding the types of PA programs induced the AMA to deny the AAPA involvement in the process of formulating national educational standards and a system of accreditation. In 1971, the AMA directed its Council on Health Manpower to develop a national program of certification for primary care PAs. The National Board of Medical Examiners, with its considerable experience in medical testing, collaborated with the AMA to form advisory committee to design the certifying examination. Although Stephen Turnipseed, a graduate of the first MEDEX class, and I were on the advisory committee, we were denied input in developing the exam. By December 1971, however, the "Essentials for an Approved Educational Program for the Assistant to the Primary Care Physician" were adopted by the AMA House of Delegates.[15, 16]

Thus the challenges facing Thomas Godkins when he became AAPA president in November 1971 were formidable but not insurmountable. He convinced the AAPA's board of directors and membership to change the organization's name to the American Academy of Physician Assistants and expand the membership criteria to include all types of formally trained PAs. He then increased the liaison activities of the AAPA by expanding the board of advisors to include representatives from the American Academy of Pediatrics, the American College of Surgeons, and the American Academy of Family Practice.

A Broader Point of View for the AAPA

Godkins also established a standard format for his board meetings that served the Academy well. Advisors and board members had the opportunity to interact on a personal level during a social hour the evening before the meeting. During the meeting, business details were settled quickly, and the rest of the time was devoted to stimulate discussions, with advisors often presenting mini-seminars on topics related to various elements of organized medicine, medical credentialing, medical education, legal issues, or economics. These discussions with advisors broadened the board of directors' point of view, giving a global context to policy decisions that had previously provoked heated discussions.

■ AAPA AND APAP JOIN FORCES

After the Association of Physician Assistant Programs (APAP) was established in 1972 to foster the concept of PAs, both the APAP and the AAPA realized that they shared many interests and concerns. The two organizations joined forces in a meeting with federal officials at the U. S. Department of Education to put pressure on the AMA to allow PAs substantive involvement in developing an accreditation program for their profession. Although the AMA had accepted the 1971 "Program for National Certification of Physician's Assistants" as "the best safeguard against incurring liability for the acts" of PAs under a physician's supervision[17] and viewed a national proficiency examination as a means of developing the PA concept under medical guidance,[14] it still opposed the involvement of PAs in a registry or commission that would administer the exam.

Representatives of the AAPA and the APAP also worked together to develop a foundation grant that would fund a joint office in the Washington, D.C., area. By 1973, grants were obtained from the Robert Wood Johnson Foundation, the van Ameringen Foundation, and the Ittleson Foundation to establish the national office.

The availability of an employed national office staff would provide another dimension to the operations of the AAPA and the APAP. In the following years, with

staff support, it was possible to develop and enter into a number of federal contracts designed to (1) accomplish a comprehensive review of PA continuing education leading to refinement in requirements for continuing education; (2) delineate and verify the professional, clinical, and interpersonal role responsibilities of PAs; (3) develop a system of examination and feedback for assessing each PA's area of clinical competence; and (4) generate learning materials to be used by practicing PAs interested in expanding their knowledge and capabilities in selected areas of practice.[18,19]

Each of these activities required input from many areas of organized medicine, state regulatory agencies, and the federal government to nurture still greater understanding of the education and practice activities of PAs. A national office made possible an organized approach to recruitment that would have a great impact on AAPA membership then and in the years to come.

■ PARTICIPATION IN THE CREDENTIALING PROCESS

Also during 1973, three PAs were appointed members-at-large to the Joint Review Committee on Educational Programs, which was jointly organized by the AMA and the National Board of Medical Examiners in 1972 to review accreditation applications and make recommendations to the Council on Medical Education (now the Committee on Allied Health Education and Accreditation). Stephen Turnipseed of MEDEX, Gail Spears of CHA, and I served as representatives of our individual training program models. The AAPA as the official PA association was denied representation.[20,21]

That same year, the AAPA offered the first National Board Review course to help PA candidates prepare for the first certification examination. The National Board of Medical Examiners issued the first exam in December 1973.[22]

By 1974, the collaboration of the AAPA and the APAP once again assisted in the credentialing process. Cognizant of a growing public distrust of the ability of health professions to regulate themselves, the AAPA and the APAP decided to establish a credentialing body at arm's length from the profession. The National Commission on Certification of Physician Assistants (NCCPA) was established in Atlanta, Georgia, to determine eligibility criteria and to administer the national certifying examination. The NCCPA is unique in that it is composed primarily of representatives from other health professions and the public, with a minority of the commissioners drawn from the PA profession. The NCCPA assumed the responsibility of administering the national certifying examination for PAs in 1975.

The AAPA and the APAP also recognized that the public was aware of the rapid pace of medical technology development, and from the outset they agreed that the NCCPA would require active participation and documentation of continuing education during a certain period of time. The commission adopted the AAPA's requirement that members demonstrate 50 of continuing education each year or 100 hours every 2 years. In addition, the commission required PAs to take a recertifying examination every 6 years.

■ FORMAL RECOGNITION AND NEW OPPORTUNITIES

During the 1974 to 1975 tenure of President Carl Fasser the AAPA received the long-desired formal recognition of the AMA and gained three seats on the Joint Review Committee. Fasser also appointed a group to work with federal agencies in an effort to ease restrictive classification standards that adversely affected PAs working in federal agencies and to begin to address issues associated with commissioning PAs as officers in all branches of the military. By now, the long, hard road of problem solving was in the past, and the AAPA could begin to plan for the future, choosing for itself the types of roads it would take.

In 1975, Thomas Godkins and I, who were both past presidents of the AAPA, President Carl Fasser, and Executive Director Donald Fisher met with representatives of the Senate Finance Committee to discuss the need to change the restrictive language in Medicare regulations, which were adopted before the inception of the PA profession. As a result of this meeting, Fasser and I were appointed as consultants to work with the University of Southern California research group that was awarded the federal contract to study Medicare reimbursement. We found that the preliminary findings of this study, the Physician Extender (PE) Reimbursement Experiment, indicated that practices with PEs had more patient encounters than non-PE practices.[23]

With this knowledge, Tom Godkins, who once again became AAPA president, mounted an aggressive campaign on Capitol Hill for PAs to be included as health care providers under Medicare.

Godkins and two advisors also presented a proposal to the AAPA's board of directors for differential reimbursement of PAs, noting that reimbursement should take into consideration incentive to hire but still serve the national purpose of containing medical

care costs.[23] The board refused their suggestions, with the consensus calling for rates equal to prevailing physician rates. This was motivated by forthcoming recommendations contained in a report of the PE Reimbursement Experiment that suggested seeking reimbursement at a rate equal to prevailing physician rates as a means of carrying the support of organized medicine. Ironically, the formula proposed by Godkins was within 5% of the rates allowed several years later by Congress in a bill concerning PA reimbursement in rural health clinics.

In the mid-1970s, the AAPA received the long-desired formal recognition of the AMA.

Although Medicare was the major focus of Godkins' second term as AAPA president, the following AAPA achievements were also accomplished during that time: the House of Delegates was established; the AAPA was finally able to reimburse board and committee expenses; past presidents were encouraged to serve as advisors or task force chairpersons; the Goals and Priorities committee developed position statements on foreign medical graduates, commissioning in the military, national health insurance, and peer review; the AAPA accepted responsibility for logging and reporting continuing medical education examinations; research activities increased, focusing on curriculum and competency assurance; and guidelines for continuing medical education accreditation were accepted and a self-assessment program was developed.

A FOCUS FOR ACTIVISM

The transition of leadership in 1976 to Roger Whittaker installed many of the organizational aspects of the AAPA that we see today. His first order of business involved preparing bylaw changes that would allow for chartering of constituent chapters, a step that was necessary for the apportioning of seats in the House of Delegates.

Because of Whittaker's strong personal relationship with Roger Tuskin, executive director of the American Academy of Family Practice (AAFP), and Frederick Schoen, the advisor to the AAFP, arrangements were made for the AAFP to host the first Constituent Chapters Officers Workshop in Kansas City, Missouri. During this workshop, the AAFP leaders shared years of organizational experience with chapter officers.

Formalization of the constituent chapters and the workshop was the culmination of ideas first discussed by the board of directors 7 years earlier. Whittaker closed his term of office by convening the first meeting of the AAPA House of Delegates in Houston, Texas, in 1977.

The AAPA's new president, Dan Fox, institutionalized the constituent chapter workshops and established a council of constituent chapter presidents, using them as advisors to assure that the concerns of their members were placed on the agenda.

The highlight of Fox's term in office, however, and the capstone of the AAPA's first decade of life was the signing into law of the National Rural Health Clinics Bill. The yeoman efforts of the AAPA and its leaders and advisors ended in the Oval Office with the signing by President Carter of the National Rural Health Clinic Services Act in 1978.

President Carter spoke to the AAPA delegation, stating,

> The legislation I am signing today will correct this defect in our public health insurance programs by requiring that Medicaid and Medicare programs pay for the services of physician assistants and nurse practitioners in clinics and rural areas without adequate care. This reform will guarantee greater financial stability for the clinics already in existence and help establish new clinics where they are needed most. For the academy the enactment of this law is important for many reasons, but most importantly because it represents the first major and unified effort by the profession in dealing with the U.S. Congress.

These seminal efforts set the stage for future AAPA efforts directed at the continued funding of PA programs and the inclusion of PAs under the broad umbrella of the Resource-Based Relative Value Scale system, designed to address physician fees under Part B of Medicare.

SUMMARY

Unmet demands for health care in the 1960s were the impetus for formally trained nonphysicians to carry out traditional physician functions. Confronted by the antipathy and ambivalence directed at their chosen profession, the former military corpsmen who were enrolled in the Duke University Medical Center PA Program organized professionally and initiated activities that led to greater opportunities for those who chose to follow the same path. The energies and frustrations of these first PAs were channeled through the AAPA, which was incorporated in 1968, and their interactions with other professional organizations gave them the knowledge, the vision, and the means by which to modify the academy over time to provide

greater professional service and development to its members and to future PAs.

Barriers to the broader use of PAs have fallen, standards for accreditation and practitioner certification have been developed, and the academy now speaks for the entire profession. Organized medicine, credentialing bodies, state medical boards, federal agencies, and Congress look to the AAPA for help in developing guidelines for employment in the federal health care system. The AAPA's research has delineated the practice responsibilities of the profession, devised a cutting-edge program of performance self-assessment, and interfaced continuing medical education with the demonstration of continued competence.

The milestones reached in the formative years of our profession were the result of vision, self-determination, and willingness to learn from the efforts of others. These guiding principles are especially important today as AAPA moves to shape the future practice environment for PAs, addresses trends toward specialization within the profession, and implements mechanisms designed to assume continued competence. The challenge before our leaders today is to shape the vision for tomorrow. ■

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National PA Day

October 6, 1992

In observance of the first graduating PA class from Duke University, October 6, 1967.