

Physician assistants are currently in higher demand than ever before. Since the first program was founded at Duke University School of Medicine in 1965 by Eugene A. Stead, Jr. MD, the scope and magnitude of the profession has multiplied exponentially. According to the American Academy of Physician Assistants, a physician's assistant is defined as a "health professional licensed to practice medicine with physician supervision" (White, 1). This fundamental rationale is still the underlying basis of the PA profession, but the responsibility of a PA continues to expand depending on the level of authority physicians delegate to non-physician practitioners. This paper will discuss some of the major developments in the PA field and address some key issues of debate.

## EDUCATION

To discuss the underlying conflicts concerning physician assistants, it is necessary to understand the methods of PA programs. The PA profession is oriented towards providing primary care with a focus on health care prevention (Jacobson, 5). Physician assistants are educated according to a compressed version of the medical school model, often alongside medical students. Students are trained to be professionals, but professionals who function dependently on physicians (Jacobson, 8). During the minimum two year program, students complete didactic and complete clinical rotations in a wide variety of areas. The program also has prerequisites similar to those of medical schools: prerequisites in basic sciences, behavioral sciences, and some sort of exposure to the medical field. The majority of accredited programs require a minimum amount of logged hands-on patient care, thus making registered nurses, emergency medical

technicians, and physical therapists prime candidates for a slot in PA programs. The behavioral science requirement reflects the PA orientation toward preventive medical medicine. Jacobson speculates that the orientation of PA programs toward hands-on patient care is directly connected with the fact that PAs tend to spend more time with patients (Jacobson, 5).

#### CENTRAL DEBATE

How competent are PAs? This is the critical question asked by both physicians and patients. The primary debate within the medical field concerning PAs is how far the scope should extend. This is partly controlled by legislation, but it is mainly a question of the relationship between physician and PA. George White, Jr. reports that physician assistant students on average complete more than 2,000 hours of supervised clinical practice during their 2 year program (White). This is comparable to the time devoted to a medical student's residency. It is not uncommon for physician assistants and medical students to do rotations together. The PA program equips physician assistants to function in a primary care role, but as shown by the directives of PA programs, PAs are trained to work in conjunction with a supervising physician. Therefore, the scope of the PA practice depends on the physician; so, often it is not a question of the competency of the PA, but a question of comfort level, experience, and practice specifics. The comfort level restraint is directly connected to the physician. Even though a physician may or may not actually see a patient they are still accountable for the patient's care. In the words of one physician, "Independence is different from accountability" (Jacobson, 7). Jacobson also found that experience influences the scope of PA practice. PAs develop areas of expertise and show that they are competent in many areas (Jacobson, 8). The role of PAs now

includes surgical practice and primary and specialty care. Many programs have a surgical or specialty focus that allows PAs to function within these areas under the supervision of a physician. Recent legislation has allowed PAs to prescribe medication for patients in 15 states. The third factor in the scope of PA practice is specific to the area of practice. Many offices are overloaded with patients, and PAs are well-equipped to treat standard cases. The shortage of primary care physicians largely explains for the expanded use of PAs (Jacobson, 8). In these cases, the scope of practice depends on the relationship between the PA and physician is decided by a PAs ability and discretion to refer complex cases to a supervising physician.

While the fundamental rationale of the profession is the relationship between physician and PA, the fundamental trend has been increasing interactivity with patients based on accessibility and increasing responsibility based on experience and demand. Mark Moran notes that PA duties include performing diagnostic tests, prescribing medicine, developing treatment plans, and carrying them out (Moran, 1). Not only are PAs approachable, they are generally up-to-date on medical innovation. In order to retain certification, a physician assistant takes a national recertification exam and completes 100 hours of continuing medical education every two years (White, 3).

#### INCREASED OPPORTUNITY

Physician assistant programs are currently on the rise. The number of programs established increased 50% between 1992 and 1997, graduating double the number of PAs (ACP, 3). Simultaneously, the number of PAs specializing in fields such as pediatrics, surgery, and psychiatry continues to increase. Mark Moran discusses the growing need

for PAs or “extenders” in specialty fields. In Moran’s article, Peggy Jacklich, a PA practicing in an outpatient psychiatry office, claims that because the office hired her the waiting list has decreased from an average of three to four months to approximately one to two weeks. Because in most states they can order standard tests, write prescriptions, diagnose, counsel on preventative health care, assist in surgery, and provide prolonged treatment, PAs greatly alleviate patient overload. (AAPA, 1) Fifteen states have passed statutes regarding PA authority to prescribe medicines. For example, Tennessee allows a supervising physician to give a PA the authority to issue and/or prescribe controlled substance and legend drugs in Schedules II, III, IV, and V (ACP, 4). According to the American Academy of Physician Assistants (AAPA, 2), the profession is becoming more widely recognized and the number of PAs is escalating as more doctors employ them (AAPA, 1). Most PAs describe their interaction with physicians as “collaborative and collegial.” One physician said that “PAs do everything I do. I consult with them as much as they consult with me. We see ourselves as colleagues” (Jacobson, 7). In 2003, the AAPA reported that the percentage of PAs practicing in a physician’s office rose from 40.3% in 2002 to 42.3%; in comparison, in 1998 only 35.3% of PAs reported working in a physician group practice (AAPA, 2). With the growth of the PA field, AAPA surveys indicate a trend towards specialty PAs. Programs train PAs in primary care; however, approximately half serve in specialty roles (ACP, 2). Jacobson notes that PAs can competently perform between 50% to 90% of tasks performed in primary care practices (Jacobson, 2). Accessibility through teamwork has broken down many barriers between PAs and physicians in primary care and has invited PAs to help alleviate overload in more specialized areas. There are no conclusive results on the direction that the PA

profession will take, but if the general trend continues, the demand for PAs will continue to increase and PAs and physicians will become increasingly interdependent.