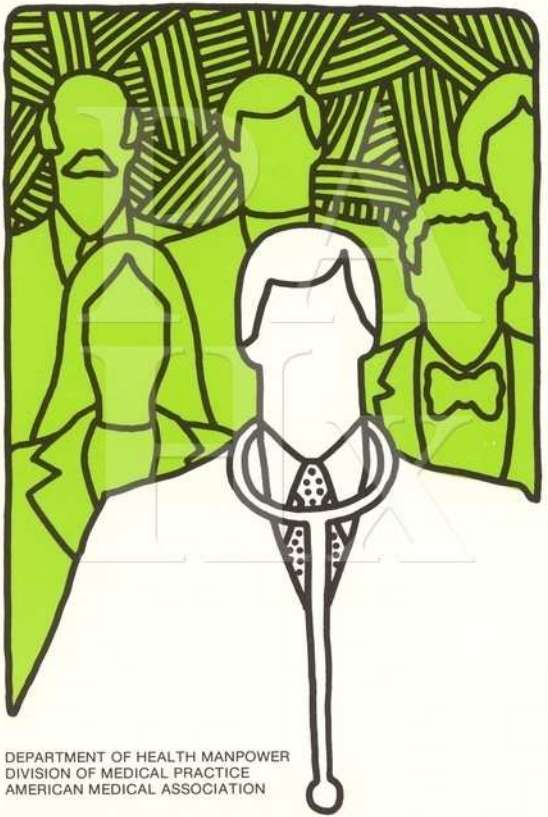
Employment & Use Of Physician's Assistants

A GUIDE FOR PHYSICIANS



DEPARTMENT OF HEALTH MANPOWER
DIVISION OF MEDICAL PRACTICE
AMERICAN MEDICAL ASSOCIATION

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Introduction

Development of new categories of physician's assistants as one method of increasing a physician's productivity is of high interest currently.Over 2000 such assistants are now working in various health settings around the country, and their ranks are expected to grow at an annual rate of approximately 1000.

This guide has been prepared by the American Medical Association in an effort to answer some of the questions most frequently asked by physicians who are considering the employment of physician's assistants in their practice. Sources of additional, more detailed information are identified in the text wherever appropriate.

What is a physician's assistant (PA)?

The past few years have seen extensive activity by educational institutions in various parts of the United States in developing new types of physician-support occupations termed "physician's assistants." The basic concept of a physician's assistant and the delegation of physicians' tasks are not new. Physicians have been delegating tasks of all kinds to medical office assistants and nurses for years. What is new is the development of formal training programs in university medical centers and elsewhere to prepare new categories of personnel to extend the physician's capabilities in the diagnostic and therapeutic management of patients. Such personnel are trained to perform tasks which must otherwise be performed by doctors themselves, even though they do not necessarily require the knowledge of a doctor. Their help frees a physician to focus his skills where they are most needed and often allows him to treat additional patients.

In December 1970, the American Medical Association adopted the following working definition of the general term "physician's assistant:"

> *"The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."*

There is strong preference within organized medicine for the term "physician's assistant" as opposed to "physician's associate," since the latter term is commonly used in referring to another physician.

What is the PA prepared to do for the physician?

Included under the generic term "physician's assistant" are persons being trained to work in a variety of medical specialty areas, at different levels of responsibility, and with different specific occupational titles, including "physician's assistant," "physician's associate," "MEDEX," "child health associate" and others. Thus the actual job functions of a "physician's assistant" will vary with the above factors. A number of training programs are preparing physician's assistants who will work for the primary care physician (family practitioner, internist or pediatrician). Others are preparing individuals to work primarily in such specialty areas as general surgery, urology, ophthalmology, anesthesiology, obstetrics and gynecology, and pathology. The American Medical Association's Council on Health Manpower has collaborated with the appropriate medical specialty societies in developing job descriptions for a number of different types of physician's assistants, including Assistant to the Primary Care Physician, Surgeon's Assistant and Urologic Physician's Assistant. Copies of these job descriptions may be obtained from the AMA Department of Health Manpower, or the medical specialty society concerned.

The job description for the primary care PA, for example, identifies the following areas in which that PA may function: (a) diagnostic services; (b) continuing medical care for chronic disease and pregnancy; (c) care of acute disease and injury; (d) rehabilitation; (e) health maintenance; ((f) health services to the community at large.

"The tasks performed by the (primary care) PA are those which require technical skills, execution of standing orders, routine patient care tasks, and such complicated diagnostic and therapeutic procedures as the physician may wish to assign to the assistant after he has attained and demonstrated his proficiency through adequate instruction and for whose provision the doctor is willing to accept responsibility. The PA may be responsible for keeping complete records of all events and results of encounters with patients, whether by direct contact with patients or by telephone. These entries should be consistent in format and content with the entire record kept on the patient."[1]

Job descriptions for physician's assistants in other specialty areas are also being studied by the AMA, or are available from the appropriate medical specialty society. The Board of Medicine of the National Academy of Sciences has categorized the physician's assistant into three broad functional levels—A, B and C—distinguished by the nature of the service each level is best equipped to render, and the depth and breadth of medical knowledge and judgment required.

"The Type A assistant is capable of . . . collecting historical and physical data, organizing these data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic steps. He is also capable of assisting the physician by performing diagnostic and therapeutic procedures and coordinating the roles of other, more technical assistants. He is distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment.

"The Type B assistant, while not equipped with general knowledge and skills relative to the whole range of medical care, possesses exceptional skill in one clinical specialty or, more commonly, in certain procedures within such a specialty. Because his knowledge and skill are limited to a particular specialty, he is less qualified for independent action.

"The Type C assistant is capable of performing a variety of tasks over the whole range of medical care under the supervision of a physician, although he does not possess the level of medical knowledge necessary to integrate and interpret findings. He is similar to a Type A assistant in the number of areas in which he can perform, but he cannot exercise the degree of independent synthesis and judgment of which Type A is capable."[2]

While there are exceptions, the more than 50 programs currently training assistants to the primary care physician are generally preparing such individuals to function at a Type A level of responsibility, while an equal number of programs training assistants in other specialties may be preparing them to function

at any one of the three levels, depending on the specialty and the program concerned.

The PA may serve the patients of his employer in all types of care settings: physician's office, clinic, hospital, patient's home, extended care facility or nursing home. The physician need not be physically present for every task his PA performs. However, the PA always works under the general supervision of the physician who retains overall responsibility for patient care.

How and where are PA's being trained?

A "Directory of Programs–Training Physician Support Personnel"[3] prepared jointly by the AMA Department of Health Manpower and the DHEW Bureau of Health Resources Development is a comprehensive listing of all known training programs for physician support personnel in operation or planned as of September, 1974 and replaces the DHEW publication No. (NIH) 74-318, "A Summary of Training Programs-Physician Support Personnel." This Directory is available from either source, and contains information on over 80 programs.

Current training programs vary in scope and emphasis, depending on the proposed job role of the assistant being trained. Length of training ranges from 12 months to five years, and educational settings include medical schools and medical centers, public and private hospitals, clinics, community colleges, colleges and universities. Prerequisites for admission vary from high school graduation and/or experience as a military corpsman to possession of a baccalaureate degree. Credentials awarded vary from certificates to associate, baccalaureate, or higher degrees. The kind of educational preparation that will be adequate and appropriate for training such individuals is currently a subject of considerable discussion among medical and allied medical educators.

The medical profession believes that clinical affiliation is an essential element of any educational program for the PA. It is envisioned that such clinical training can often be conducted in a model practice unit of a university-affiliated or community teaching hospital.

What recognition of qualifications will be given to the PA and to his training programs?

The American Medical Association has strongly endorsed the concept of innovation and experimentation in developing new categories of health manpower. This "accelerated evolution" in new types of assisting personnel will possibly enable the health manpower pool to expand at a faster rate than would be possible otherwise and thereby assist in increasing the supply of health services. However, it is important that services rendered by any new level of medical worker be consistent with accepted standards of quality care.

The American Medical Association carries on three activities to achieve such consistency. The first involves evaluation of the need for, and appropriate functions of a new health occupation. The AMA, working in collaboration with the organization representing potential physician employers—usually the appropriate medical specialty society—determines if a national need to develop and use a new category of support personnel exists. When such a need is demonstrated and the functions to be delegated have been clearly defined, a "job description" prepared by the group representing potential employers is reviewed and approved. The sponsoring organization is then invited to collaborate with the AMA and other appropriate groups in accrediting education programs for the occupation.

A second major activity involved cooperation with the National Board of Medical Examiners in development of a national proficiency examination for the assistant to the primary care physician, and subsequent establishment with thirteen other national groups of an independent National Commission on Certification of Physician's Assistants. The new Commission will certify those PAs successfully completing the primary care examination (administered annually) and meeting other criteria; study of extending certification to PAs working in other specialty areas is now underway.

Such national certification will help maintain high standards in the occupation and will provide the potential physician employer with acceptable evidence of competency.

The third major AMA activity is the accreditation of educational programs. The AMA Council on Medical Education, in addition to maintaining standards for medical education, develops and maintains standards for accreditation of allied medical education programs. As of August, 1974, it was the accrediting agency for training programs in 28 different allied medical occupations, including the assistant to the primary care physician, urologic physician's assistant and surgeon's assistant. Lists of the PA education programs accredited by the Council on Medical Education are available on request from the AMA's Department of Allied Medical Professions and Services.

What limits are being placed on employment and functions of PAs–nationally and at the state level?

Because of the variation in patterns or settings under which medical care is provided across the country, the AMA believes that national lists of permissible functions to be delegated to different types of PAs are neither practical nor desirable. As a general rule of law, physicians, who hold unlimited licensure, may delegate patient care tasks to non-licensed individuals who appear competent to perform such tasks without fear of increased exposure to legal liability. There are certain limitations on a physician's delegatory powers, however. Physicians should delegate such tasks to individuals qualified by education, special training or experience to perform the tasks competently, and should be satisfied that the tasks delegated will not jeopardize the patient's safety or well-being.

According to Dr. Francis C. Coleman, past chairman of the AMA Council on Health Manpower, "we believe that functions appropriate for delegation to the PA can best be determined by each individual physician in accordance with the above limitations and in terms of the capabilities of his particular assistant. The American Medical Association has further recommended that, pending more experience with PAs, such individual "utilization plans" be submitted to and approved by the medical licensing authority in that physician's state."

Such approval mechanisms are already in operation in a number of jurisdictions. As of March, 1975, 37 states had enacted legislation establishing some type of regulatory mechanism for PAs. An analysis of state laws shows that two distinct statutory forms are used to grant legislative sanction to physician's assistants. One type of law simply spells out in the state medical practice act the physician's recognized right to delegate tasks to a trained assistant. This approach is referred to as the general delegatory statute and can be illustrated by the Connecticut law which states:

> *"The provision of this chapter (Medical Practice Act) shall not apply to . . . any person rendering service as a physician's trained assistant, a registered nurse, or a licensed practical nurse, if such service is rendered under the supervision, control and responsibility of a licensed physician."*

Of the 37 states, 17 had enacted this form of general delegatory authority statute with wording differing only slightly from that of Connecticut law. In addition to Connecticut, they are Alaska, Arizona, Arkansas, Colorado, Delaware, Georgia, Hawaii, Idaho, Kansas, Maine, Maryland, Montana, North Carolina, Oklahoma, Tennessee, and Utah.

Eighteen other state legislatures had enacted laws which authorized a specific organizational entity, usually the state board of medical examiners, to establish rules and regulations with respect to a PA's educational and employment qualifications, and in cases to approve employment of a PA by a specific physician, based on a proposed job description submitted by the would-be employer. This type of law, referred to as the regulatory authority statute, has been enacted in Alabama, California, Iowa, Massachusetts, Michigan, Nebraska, Nevada, New Hampshire, New Mexico, New York, Oregon, South Carolina, South Dakota, Vermont, Washington, West Virginia, Wisconsin, and Wyoming. Two states—Florida and Virginia—have both delegatory and regulatory statutes. In some of these states, the number of PAs a physician may employ is limited to one or two. It is interesting to note that Colorado has both the general delegatory provision and a formal practice act for the "child health associate." Nevada legislation on the subject is unique in that regulatory authority is vested in the State Board of Osteopathy.

What degree of supervision should the physician give the PA?

Of the numerous questions raised about the employment of PAs, one of the most important is the amount and type of supervision they should receive—

particularly in the case of the "Type A" assistant, who is trained to exercise some degree of independent judgment. There is as yet little consensus, even by experts, on this issue. Some contend that the relatively brief period of formal training received by many PAs makes it necessary for the employing physician to provide over-the-shoulder personal supervision. Others believe that the PA should have more responsibility and should be permitted to perform the tasks for which he is trained and qualified, away from the physical presence of his employer, so long as he is able to communicate in an acceptable manner with the physician as the need arises.

Under all currently effective state laws, PAs are required to function under the supervision, direction or control of a licensed physician. However, both the state legislatures and the courts apparently have avoided defining acceptable physician "supervision" to any significant degree. Three operating levels of supervision are apparently being considered—over the shoulder, on the premises, and remote with monitoring or communication between the physician and the PA.

The words "under the direction and supervision of a licensed physician" used in most of the PA statutes do not require the physician to be looking over the shoulder of the assistant, nor do they require his presence in the same room. What they *do* require is unclear. The courts can be expected to interpret "supervision" to mean "reasonable supervision." This means that the degree of supervision required will vary according to the facts and circumstances involved in any given case. Other than that general statement, one must wait for judicial interpretation on a case by case basis to begin to define more specifically what "supervision" involves.

In the absence of a comprehensive legal or administrative definition of supervision, the rule of reason adopted by the courts would take into account all the surrounding circumstances, including a balancing of the interests involved. For example, in addition to prior case law and any pertinent laws of other states, reviewing courts would pay attention, as in many cases involving physicians, to the "custom and usage" of the profession, i.e., how physicians are presently utilizing and supervising their assistants. To obtain more information on present utilization and supervision patterns, the AMA Department of Health Manpower has surveyed over 400 working graduates of formal PA training programs to determine the degree of supervision provided for 107 specific health care tasks. Results of this survey are available on request.[4]

On the whole, it is not anticipated that the courts will define "supervision" rigidly, given the wide variety of practice settings, types of practice, and kinds of tasks the assistant would perform. Whether in an underdoctored area greater flexibility in supervision requirements will be allowed so that more people can receive adequate health care is unknown. The motives of the supervising physician may well be a factor in a balancing of the interest involved. Thus, there might be a tendency for the court to allow broader discretionary supervision when there is a bonafide attempt to provide needed care and to narrow that discretion where the motive appears to be profiteering. A too rigid definition of supervision by the courts, legislatures or boards of medical examiners would tend to dilute the effectiveness of the utilization of physician's assistants in the delivery of needed services.

How can a physician obtain the services of a PA?

Program directors identified in the "Directory of Programs" mentioned on page 7 may have listings of their graduates. The "Directory" lists programs by state in the following categories: Programs to Train Assistants to the Primary Care Physician; Programs to Train Assistants for a Specialty and Programs to Train Assistants for Primary and/or Specialty Physicians. Such program directors can also be contacted through the Association of Physicians' Assistant Programs in Washington, D. C. Two national organizations for physician's assistants are the American Academy of Physician's Assistants in Washington, D. C., established in 1968, and the American Association of Physician's Assistants in New York City, established in 1971. The appropriate medical specialty society is another potential source of information on PAs trained in that specialty. Lists of Primary Care PAs who have successfully passed the certification examination will be published after each administration of the examination by the National Commission on Certification of Physician's Assistants.

How should the PA relate to the physician's office nurse?

The relationship between the PA and office nurse will, of course, vary to some extent with the training and capabilities of the particular individuals involved, as well as with the additional personnel, such as receptionists or file clerks which may be employed in the practice.

On the whole, the nurse's duties will lie primarily within the state nursing practice act or legal definition of nursing, by contrast with the physician's assistant, who will in many instances be performing delegated functions formerly provided by the physician. Perhaps the most satisfactory way to approach the initial working relationship between the office nurse and the PA is that they be treated and perceive themselves as equals. Given a working environment, they will learn from each other. Typically, the office nurse will have been on the scene for some time and therefore feel some right to seniority.

Typically, the PA will be accustomed to working hand-in-glove with the doctor and may unwittingly usurp the office nurse's position as "first assistant." It is important that misunderstandings be prevented for the sake of the *esprit de corps* that makes for a smoothly running practice. The PA is still a poorly understood member of the health team and the physician must therefore inform his office nurse as to what this person has been trained to do and will be expected to do in the particular practice. When a physician needs an extra hand, no one will recognize it better than the office nurse. However, both have probably been overworked so that the nurse may well have been functioning in part as a PA. With proper management most employees welcome the chance to revert to the tasks they do best when more help arrives. If, however, the nurse has enjoyed

performing certain tasks that the PA is also qualified to perform, changes should be considered cautiously. Patients' welfare is the ultimate criterion and the PA is being hired to more adequately provide for such welfare. The care entailed should not be sharply delineated by doctor's chores, nurse's chores, or PAs chores. The functions of health team members will vary and overlap to some degree according to the personalities and talents involved. Too much overlap, on the other hand, should be avoided. That is, "everybody's job is nobody's job" and employees need the security of knowing what is expected of them. To achieve this, the physician should call staff meetings with all members present to outline his expectations in detail, ask for suggestions, opinions, etc., and generally work toward group satisfaction.

One potential source of friction may occur when the nurse is asked to provide some services for the PA that she also provides for the physician. The idea is not to place the nurse in a subsidiary role to the PA but rather that the PA's training is such as to enable him(her) to really extend the capabilities of the physician. This relationship needs to be worked out early and openly.

How should a PA be introduced to patients, and what acceptance of him/her can be expected?

Acceptance by patients is an important consideration when employing a PA. To any physician who plans to use a PA in his office or hospital practice, the American Medical Association's Office of the General Counsel recommends that the assistant be introduced and identified by role to all patients for whom he may provide services; that the physician not delegate any patient care functions to such an assistant when a patient indicates an unwillingness to have the function in question performed by anyone other than the physician; and that the physician be alert for patient complaints concerning the type of quality of services provided by such an assistant. This advice is based upon legal considerations and is designed to lessen the possibility of a patient suing the physician because of disappointment or dissatisfaction following a physician's failure to fully inform the patient of the role of the assistant and obtain his consent. If a conscious patient accepts the services of a physician's assistant without objection, consent may be implied from the circumstances.

It is recommended that the physician personally introduce the PA to each patient at the first contact and emphasize that though not a doctor, he is trained to assist the physician in performing selected diagnostic and therapeutic services, always under the direction or supervision of the physician.

Acceptance of the PA by patients is generally reported to be good, according to limited studies by Duke University. The poorest acceptance was usually demonstrated by patients at the lower and higher extremes of the economic spectrum. It was theorized that patients in the low income groups believe that

the PA is being substituted for the doctor and they become the recipients of secondary health care because of their economic status. The well-to-do tend to feel that because of their ability to pay for the best of medical care, they are receiving something less when attended by a PA. The majority of people in the middle income brackets apparently accepted the PA without significant reservation.[5]

In a more recent evaluation it was found that patients readily accepted the PA for routine treatment, but felt that there were certain procedures that should be attended to by the physician only. None of the people interviewed stated they would prefer to see a doctor for all their medical care. The researchers concluded that properly trained and introduced PAs will find that patients will accept them as they have long accepted other members of the health care team.[6]

Can a physician's PA work for him in a hospital?

The AMA believes it is perfectly appropriate for the PA to provide services to hospitalized patients of his physician employer, under the direction of that employer, if hospital policy permits it. To assist the hospital medical staff in regulating and guiding the use of PAs in the hospital, the AMA has adopted a statement on "Status and Utilization of Expanding and Emerging Health Professionals in Hospitals." This statement calls for the medical staff to recommend to the hospital governing authority the extent of functions that may be delegated to such emerging health professions as the PA, to determine the general qualifications to be required of members of each of these health professions, and to specify appropriate use of such personnel in each individual instance based on the professional training, experience and demonstrated competency of the PA and his employing physician. Under such a mechanism, the practicing physician who wishes to use his PA in caring for his hospitalized patients should contact the credentials or other appropriate committee of the hospital medical staff, providing the committee with a description of the way he intends to use the PA, and the functions such an individual will perform in the hospital, along with information on the PA's training and qualifications.

The American Medical Association has been concerned with the potential problems which could arise from the employment of physician's assistants directly by hospitals. The AMA believes that direct responsibility to and supervision by a physician is a critical element in the safe and effective performance of a physician's assistant. In June, 1972, the AMA adopted a recommendation that a physician's assistant not function in that capacity when he is an employee of and paid by a hospital or by a full-time salaried hospital-based physician.

Although not explicitly stated, this recommendation was designed to apply primarily to the assistant to the primary care physician, who functions at the judgmental level designated as "Type A" by the National Academy of Sciences.

It was felt that a close one-to-one working relationship with an employer physician is vital to the safe and effective performance of such an assistant.

How and how much should a PA be paid?

The physician's assistant is an employee of the doctor and therefore should be paid by him. According to the Department of Health Manpower Study of Physician's Assistants, salary scales range from just under $7,500 to just over $22,500 annually, depending upon the education, training, experience and performance ability of the PA and the size and location of the physician's practice. Mean annual income from all respondents was about $11,560; males averaged $12,015 and females $9,975. Fully one-third of the respondents were in the $10,000-$12,499 salary range. Mean annual income for 16 of the 24 specialties reviewed was in excess of $10,000 but the number of responses in some specialties were too few to permit generalization. Highest salaries reported were for PAs in the field of radiology; the lowest were in public health, physical medicine and dermatology. The primary care specialties of family practice, internal medicine and pediatrics were all clustered in the $10,000-$12,500 range.

The AMA has recommended that reimbursement for services of a physician's assistant be made directly to the employing physician. In instances where the PA is providing services in the physician's office and in conjunction with the physician, the cost of such services would appropriately be a part of the physician's own fee-for-service as is now the case with other personnel he employs. When the PA provides physician-like services to a patient under the direction of, but in a location physically remote from the employing physician, AMA has recommended that the physician bill for such services on the basis of the usual, customary and reasonable charges concept, insofar as this may be established by custom and experience for the physician's assistant. With experience, the physician may find that he can adjust his charges for such services to reflect the actual cost of their being provided by the PA rather than by the physician.

Reimbursement by some third party payors for PA services provided away from the physical presence of the physician is sometimes difficult to obtain currently. According to Dr. Maynard I. Shapiro, a past Vice Chairman of the Council on Health Manpower, "Both the Medicare program and other third party payors are reluctant to reimburse the physicians for such services without some professional assurance as to the quality and safety of the care provided in this semi-independent setting. We believe that the PA approval mechanisms now being established within the state medical licensing authorities in many jurisdictions will provide such assurance, in that the proposed functions of PAs in remote areas will be approved on an individual basis. Accordingly, AMA has recommended that reimbursement be made by third party payors for PA services where this mechanism exists, and this recommendation is currently under study by such third party payors." A report on this subject

titled "Guidelines for Compensating Physicians for Services of Physician's Assistants" is available from the AMA Department of Health Manpower.

Should a physician change his professional liability coverage when employing a PA?

A physician who is considering employment of a physician's assistant should always consult his insurance carrier, to make certain that his liability for acts of the assistant is covered. Since the number of patients treated with the use of an assistant may be expected to increase, the physician should also consider whether the limits of coverage of his insurance is increased.

Whether it is necessary or desirable for a physician's assistant to have insurance to cover his personal liability is debatable. His physician employer is more likely to be sued, except that the assistant may become a likely target if he has insurance. On the other hand, a successful suit against an assistant, however remote the possibility, might result in the loss of all his assets if he has no insurance.

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