THE NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN'S ASSISTANTS

COMPENTENCY EVALUATION OF PHYSICIAN'S ASSISTANTS IN MEDICAL SPECIALTIES

The title, "Physician's Assistant" (PA), as interpreted by NCCPA, is a generic term referring to a class of mid-level health practitioner who performs tasks traditionally within the purview of physicians and under the supervision of a clearly identified physician. In many instances, those people who qualify as PA's may perform under different titles such as: physician's associate, child health associate, Medex, nurse practitioner, nurse clinician, surgeon's assistant, surgical physician's assistant, etc. Although the major training emphasis has been in primary care, PA's function in a wide variety of specialty settings.

Historically, PA's perform an evaluative function; they are capable of eliciting a complete history and performing routine physicial examinations on all types and ages of patients and across all body systems. Additionally, PA's can order and/or perform non-life-threatening diagnostic procedures and can interpret results and isolate abnormalities. They are also trained to carry out specific management regimens under physician direction and to take necessary, immediate action to preserve life in emergency situations. They often perform minor surgical services (e.g., removal of foreign objects from eyes, minor sutures, etc.). PA's may perform other isolated functions specific to the specialty setting in which they work. It is important to emphasize that PA's are not independent; they must work under physician supervision, and the identified physician supervisor is clearly responsible for the PA's professional activity.

PA programs developed and proliferated in the late 1960's and early 1970's with major emphasis in one specialty area: primary care. The efforts of organizations, including the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American College of Surgeons, American Medical Association, and American Society of Internal Medicine brought focus to the need that mechanisms and formal sets of essentials were necessary to accredit training programs in order to assure the quality of the education processes. Consequently the above listed organizations developed the Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician, which were adopted by the American Medical Association and all the other collaborating organizations in 1971. Following this, the involved organizations formed the Joint Review Committee on Educational Programs for Assistants to the Primary Care Physician, which was charged with the responsibility of reviewing and recommending accreditation of Programs, to the AMA Council on Medical Education, through it's Advisory Committee on Allied Health. It was understood that surgeon assistants (SA) programs would be accredited by the American College of Surgeons, which subsequently generated appropriate essentials for SA training programs. The AMA adopted these essentials and in an effort to provide generic accreditation, the two processes were then merged in 1976 to form the Joint Review Committee on Educational Programs for Physician's Assistants (JRC-PA), which now functions ~~in~~ under the aegis with the Committee on Allied Health Education and Accreditation (CAHEA). CAHEA accredits both primary care and surgical programs as physician assistant programs. Accreditation is awarded to programs preparing

assistants to the primary care physician and surgeon's assistants when they conform with the appropriate essentials.

Such accreditation mechanisms, however, only evaluate the educational processes and not the products of the training programs. The next step, under the auspices of the federal government and private foundations and with the endorsement of the PA profession, was to develop a mechanism to assess the competency of the products of the training programs. The National Board of Medical Examiners (NBME) developed and first administered the Certifying Examination for Primary Care Physician's Assistants in December of 1973. At the same time, nurse practitioner, nurse clinician, and child health associate programs were gaining momentum; graduates of these programs were also eligible to take the examination, as were informally trained primary care PA's who had met specific, stringent eligibility criteria as attested to by supervising physicians. Since the examination was in primary care, graduates of SA programs were not eligible.

The responsibilities for establishing eligibility criteria for the examination and for subsequently certifying those who passed the examination were new and uncomfortable roles for NBME. Consequently, NBME, together with representatives of 13 other professional groups (See Table 1), agreed in late 1973 to form a free-standing, independent commission to assure the PA profession, employers, state licensing boards and, most importantly, the patients, of the competency of this new class of health professional. In February, 1975, after being formally structured, organized and funded by the Department of Health, Education and Welfare, Division of Associated Health Professions and the Robert Wood Johnson Foundation, the National Commission on Certification of Physician's Assistants (NCCPA) opened its national offices in Atlanta, Georgia.

The major charge of NCCPA has been directed toward the specialty area of largest PA concentration--primary care. DHEW has previously funded, with a few exceptions, only training programs in this specialty. Consequently, the certifying examination was developed for administration to those people who had been trained and were functioning in the primary care role.

The rapid growth of the PA concept and the resulting state rules and regulations enabling PA practice have created a dilemma for the PA who has graduated from or works in a specialty setting, most notably SA's. In many states, a PA is not allowed to practice until he is certified by NCCPA. However, the current examination is designed to measure competency in primary care only. Currently, there is not an appropriate mechanism available to evaluate the competencies of those individuals trained in specialty settings other than primary care. In order to prevent disenfranchising the SA, and only as an interim solution, graduates of accredited SA programs have been eligible to sit for the NCCPA examination since 1976.

This paper will discuss the position of NCCPA with reference to the current dilemma now facing the specialty PA with emphasis on the surgeon's assistant. Emphasis will be given to identifying the problem(s), discussing need, reviewing ways to measure specialty competency, identifying the eventually desired solution, and specifying evolutionary steps

to attain that solution.

Statement of the Issue

The substantial amount of public and private money expended to support programs training assistants to the primary care physician testifies to the degree of interest in the PA concept, notably to relieve primary care manpower shortages in medically underserved areas. There was a concern that PA's would follow the trend in medicine, and gravitate to secondary and tertiary care centers in the suburbs. The data thus far shows that this has largely not occurred, although certainly there are PA's working in such settings.[1] A substantial percentage of PA's may be found in areas of health care scarcity, and most are involved in primary care. Further, most PA's seem to be remaining in primary care as their careers.

Some surgeons have suggested that qualified SA's work in teaching centers, replacing interns and junior residents. This would allow the system to decrease the production of excess numbers of surgeons. A substitution of SA's performing some of the functions usually performed by surgical residents would also produce economies which are sorely needed. Surgical utilization data suggests that an increase in the number of surgeons increases the total volume of surgery performed.[2] This argument for training SA's is most compelling from a public policy perspective. However, it is also possible that SA training programs will develop in excess numbers relative to need, since it is possible to pay a student in training far less than one would pay a fully fledged SA in such a situation. After producing too many SA's for teaching center needs, the market might then become over-supplied, causing SA's to move into suburban practice settings in order to secure employment. NCCPA is concerned that programs carefully monitor demand for manpower and only train SA's in appropriate numbers.

The issues surrounding the certification of any and all types of specialty PA's are complex. At this time, the principal need is for a competency examination in the surgical specialty. The arguments in favor of the development of a SA examination are most compelling, but since the PA concept is still a relatively recent one, it is improtant that due caution be exercised. Undue haste in developing an independent SA examination may, if not integrated into a sensible overall strategy, lead to excessive specialization of PA's similar to that seen in medicine generally. The NCCPA intends to approach the SA examination in a manner consistent with an orderly evolution of this important, new profession.

At present, there is no nationally acceptable, clearly defined role for any specialty PA other than in primary care. A careful review of the SA field will provide a good model for generalizing to all other PA specialties. Currently, SA's seem to fall into five categories:

1. graduates of accredited SA programs;
2. graudates of primary care programs who have taken a surgical track;
3. graduates of primary care programs who are employed by surgeons;
4. informally trained SA's;
5. graduates of unaccredited SA programs.

SA's are not only trained in a variety of different settings, but they are also functioning in a variety of roles. The challenge of measuring competency in a relevant manner is, therefore, a matter of identifying the role of the SA and assuring that SA's and surgeons (and especially the American College of Surgeons) are willing to accept the identified role as being appropriate.*

NCCPA has struggled with the SA issue for three years, and has actively pursued meeting the needs of this population. During this period, many recommended solutions have evolved. First, the Specialty PA and Eligibility Committees have allowed graduates of AMA-approved SA Programs to sit for the primary care certifying examination beginning in 1976. It was decided that, although this examination is decidedly not a measure of the surgical competencies needed by an SA, eligibility offered a reasonable short term solution. This approach does not solve the basic problem, however. It requires SA's to possess what may be irrelevant knowledge and skills and does not measure competency specific to surgery. However, a number of Fellows of the American College of Surgeons have voiced the opinion that SA's do need to possess primary care competencies.

Second, in 1977 NCCPA's Eligibility Committee recommended re-evaluating the eligibility criteria for the informally trained PA. It was decided that an individual who was performing primary care functions in the employment of a surgeon and met certain eligibility criteria would be allowed to sit for the examination. This decision allowed some additional SA's to sit for the examination beginning in 1978. The issue of eligibility is still being actively examined by the appropriate committees within the Commission and it is feasible that further changes will occur in the future.

Third, NCCPA has looked at different alternatives to assessing the competence of the specialty PA. One alternative considered was to develop a separate examination for each specialty. This method would examine a highly specific knowledge base, a very favorable quality. However, it would be a very costly method. It might also create market imbalances, making it difficult for some PA's to find work. This method would also confuse the already muddy legal issue of state regulations.

A second alternative considered was to administer a core/primary care examination with specialty add-ons. This would be an easy examination to administer, but the specialty PA would be required to be knowledgeable in some areas that may not be relevant to his specialty role. Also, this method leaves one with the impression that primary care does not require special expertise.

A final alternative would require the separation of primary care from core (an activity that NCCPA has already attempted once, without success). While this type of an examination might be easy to administer, it is very difficult to develop.

* A statement of the ACS's position regarding SA's may be found in the April, 1977 (Vol. 62, No. 4) and December, 1977 (Vol. 62, No. 12) Bulletin of the American College of Surgeons.

The nature of any certifying examination requires that development of test items be very thorough. The test must possess reliability and internal validity and, must provide a broad spectrum sample of knowledge and skills necessary to perform in the professional role. One must first know the role of the population being examined. Prior to the development of the National Certifying Examination for Primary Care Physician's Assistants, detailed surveys were provided to over 800 PA's and employers. From these surveys, a series of task statements was developed; these were then reduced to a malleable number. Examination test sites were then developed on the basis of skills and knowledge necessary to perform the tasks depicted in the task statements. NCCPA has already accomplished some necessary steps in anticipation of the possible development of an interim SA examination.

After considerable discussion, NCCPA has decided to continue to strive for the development of an examination(s) that will measure the core competencies required of a generic PA while simultaneously evaluating the specialty areas in question.

Preliminary steps taken toward the Surgical Examination are representative of approaches to other specialty areas. A survey form was developed and mailed to 225 known SA's, and a similar form was sent to their employing surgeons. Based on the distribution of responses, a Test Committee will utilize the information provided from the questionnaires to begin developing test items. The Test Committee is composed of SA's, SA training program personnel, and surgeons acceptable to the ACS. The surgical examination component would emphasize general surgery but would allow for those with emphasis in a surgical sub-specialty. It seems likely that graduates of accredited surgical sub-specialty programs might eventually be eligible for the examination. To pass, one would have to have sufficient knowledge in general specialties. For example, an orthopedic assistant would be expected to do well in the general surgical questions, extremely well in the orthopedic questions, and perhaps not so well in the urological questions. This is the philosophy behind the primary care examination which has worked so extraordinarily well. It allows for a general examination while still permitting considerable latitude in training emphasis.

Position of NCCPA

At a recent NCCPA Board of Directors meeting, a decision was reached which places NCCPA in the position of accepting the responsibility for the certification of all PA's regardless of their specialty training. In concert with this, the decision was made that examinations would be developed as soon as appropriate participating organizations requested such development and funding is arranged to support such examinations.

The major goal of NCCPA is to provide a generic core examination that all PA's would have to pass. This core examination would be supplemented by additional specialty sub-parts that would be optional choices for examination candidates. NCCPA may use an interim SA examination as an initial step toward this ultimate goal. The results of this examination could be studied with the intent of identifying those items most appropriate for measuring the competency of SA's, as well as identifying those items most appropriate for developing the "core" examination.

If NCCPA pursues this option, it anticipates gaining knowledge that will enable it to develop future examinations that will not only evaluate core knowledge and skills, but will also provide a mechanism for evaluating specialty areas that an individual PA may choose. We anticipate that three to five years of experience will be needed to achieve the ultimate objective.

NCCPA has a unique responsibility as a national certifying body with its diverse representation from the health professions and the public. At this time, the Commission is uncertain about the immediacy for development of any specialty examination beyond that for Surgeon's Assistants. However, looking toward the future, NCCPA will seek to address the needs of both the public and the PA professions. To adjust this end, the Commission will periodically review professional realities and adjust it's positions as circumstances warrant.

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REFERENCES

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[2]Detmer, M.D., Don E., and Tyson, M.S., Timothy J., "Regional Differences in Surgical Care Based Upon Uniform Physician and Hospital Discharge Abstract Data," ANNALS OF SURGERY, Vol. 187 No. 2, February 1978, by J.B. Lippincott Company, page 166.