Introducing physician assistants into new roles: international experiences

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(Manuscript as published in The Medical Journal of Australia, 188 (4). p 199-201)

The development of physician assistants (PAs) is a phenomenon that has accelerated since the new century and many countries are involved (1). We report on countries that have recently introduced PAs to identify opportunities for improving the transition.

The 35th Annual Physician Assistant Conference of the American Academy of Physician Assistant (AAPA) held in Philadelphia, US, May 26-31, 2007 was attended by almost 8,000 delegates including PAs, students, academics and policy makers. The main purposes of this conference were to promote professional development, develop ideas and provide education. It also featured an international forum focusing on global developments.

Physician assistant: a possible solution to workforce shortage in Australia

PAs are a healthcare professionals licensed to practice medicine under physician supervision (2, 3). They were introduced in the US in the sixties to alleviate shortage and maldistribution of primary care physicians. The PA role has now spread outside the US with various levels of developments (Table 1) (4-10). This role is now internationally recognised as a part of a solution to combined issues of health workforce shortage and increase demand for healthcare services (11).

*** insert Table 1 here ***

Several Australian groups including public and private health providers in Queensland, the University of Queensland (Centre for Military and Veterans' Health and Centre Health Innovation and Solutions), and James Cook University are addressing medical workforce issues by piloting and advocating a PA type role as one of many solutions (12, 13).

An international forum of the AAPA conference provided an opportunity for Australian delegates to learn from experiences of other countries who have undertaken similar projects. Eight presentations during this forum focused on new and emerging roles and experiences. The Canadian and Scottish presentations were in pilot phases and considered the most relevant.

The Ontario experience

Joshua Tepper, MD, MPH, Assistant Deputy Minister from the Health Human Resources Strategy Division of the Ministry of Health and Long Term Care (MOHLTC) in Ontario, Canada provided an overview of the progress of the PA role into Ontario.

A broad initiative titled HealthForceOntario established a bold and aggressive plan to ensure the right number and mix of health care providers and to establish new and expanded roles in areas of high need. This implementation included the key following steps:

- May 2006: Enabling legislation enacted for the demonstration projects and announced at the AAPA.
- June 2006: Consultations with all stakeholders including employers, educators, regulators, health professionals (e.g. medical, nursing and allied health staff at Ontario's hospitals) and other experts (e.g. Canadian Forces, Manitoba University, Canadian Association of Physician Assistants and overseas medical workforce experts).
- August 2006: Selection of six hospitals willing to employ emergency care teams that include PAs, and nurse practitioners (NPs).
- April 2007: Definition of competencies profiles and scope of practice statements for PAs to practice in Ontario.
- May 2007: Employment of PAs and NPs to work at six selected emergency departments. Assessment begins concurrently and includes

outcomes of care for specific diagnoses, patient waiting times, access to care, satisfaction with care, and satisfaction with the PA or NP.

The rapidity of this initiative is attributed to several factors: development of strong partnerships and collaborative relationships, support from other health professions and experts in the field, high acceptance of overseas PAs participating in pilots, completion of PA competencies document, and significant government investment in success of the PA initiative.

Two elements are considered key. First, the PA role was already in place in the military as well as in the province of Manitoba (7). This allowed policy makers to refer to current experiences within the country. Second, a Physician Assistant Implementation Steering Committee was established to collaboratively guide development, implementation and evaluation of all PA projects.

This steering committee met monthly to facilitate communication. It is co-chaired by two doctors and includes a broad base of stakeholders (e.g. PA experts and educators, representatives from partner organizations, nursing, community clinics and academia). Six subcommittees and working groups responsible for research and design of key components of the project focus on developing Ontario PA competencies, defining PA scope and role definition, determining compensation, establishing educational programs, addressing liability issues, establishing evaluation, launching demonstration pilots in clinical settings, recruiting, and developing communications.

The Steering Committee, combining professional expertise, overcame a number of challenges such as recruiting the required numbers of PAs, increased workload due to aggressive timelines, and concerns from other professions about the introduction of a new and unregulated profession.

HealthForceOntario is committed to several demonstration pilots introducing PAs to the Ontario health care system through a wide range of clinical settings and using a variety of employment models throughout the province. A combination of 88 hospitals and at least five Community Health Centres expressed interest in employing a PA. Only 40 PAs are being recruited.

Until HealthForceOntario produces enough "home grown" PAs, Ontario will recruit PAs with formal education from other jurisdictions (e. g. Retired PAs from the Canadian Forces, PAs from Canada and the US eligible for Canadian PA certification).

The Scottish experience

At the 2006 AAPA Conference, Scotland announced a demonstration project that actively recruited PAs for 20 positions. A total of 240 applications were received, 45 PAs were interviewed, 20 were offered contracts and 12 American PAs arrived together to work on a two-year contract. They are deployed in demonstration projects in various Scottish sites in areas of family medicine, acute medicine and emergency medicine (10).

Dr Ricky Bhabutta, Senior Medical Officer, and Dr Patricia O'Connor from the Scottish NHS, leading the research team, discussed the first 6 months of their demonstration project that began in November 2006. PAs working in Scotland also reflected on their experiences.

One of the challenges was the logistics taken to settling the expatriates into Scottish culture. The successful aspects of their projects included:

- Preparation to 'cultural' differences of the workforce, the Health Department, the community and PAs themselves (e.g. media, local open days, leaflets, emails, conferences, teaching sessions and hospital and regional awareness campaigns).
- Country induction using a specific relocation company allowed smooth transition into "Scottish life" for the PAs. This included introduction to the cultural and social aspects of living in Scotland, introduction to the National Health System (NHS), adaptation to British medicine and to local programs.
- Central coordination and site selection by the Scottish Executive.
- Partnership with central funding for evaluations, the recruitment process and awareness raising events.
- Objective and structured behavioural interviews.
- The University of the Highlands and Islands was commissioned to compile monthly evaluation reports on all sites.
- PA development days and opportunities for feedback into the project provided opportunities for open discussions of difficulties with the project, staff or supervisors.

PAs proposed that a site visit would allow them to obtain a better set of expectations regarding the relocation and demonstration process. The lack of clarity of the job description provided a source of confusion and frustration. The recruitment period was too short. The lack of definition of supervisor role created some initial confusion.

The supervisors and project managers added that a few aspects could have been managed better such as involving doctors in the recruitment process, establishing the supervisor role, reviewing the team role of the PAs in the context of major changes in the British medical training model and obtaining positive media involvement.

A perceived hurdle for Scotland is that PA is not a registered profession in the UK. Consequently, they were currently working under a delegation and referral clause. Further discussions about developing PAs for Scotland have been centred on the cost, the necessity, and whether it would be more economical to recruit them from England and North America or start a university based program in Edinburgh.

As they work through the first half of a two year experience, the assessment team reflected on a number of observations. A needs assessment by a workforce scholar was a necessity as it provided a solid literature review on

various roles and experiences in the US and Canada (10). For instance, it prevented "name game" that England experienced (e.g. "medical care practitioner" instead of "PA"). Furthermore, drawing on American PA consultants, site visits, involving the citizenry of small towns, and attendance of conference (e.g. AAPA) was beneficial.

According to Dr Bhabutta, an British Army doctor, it is only a matter of time before PAs are dispersed throughout the North Atlantic Treaty Organization countries.

Lessons learned

The experience of two Commonwealth countries provides a method how implementation of a PA type role in Australia can be successfully achieved in a timely manner. The outcomes of this important conference revealed that reviewing the literature and incorporating the following key elements are strategies likely to ensure success. We suggest that an active steering committee composed of a broad base of stakeholders is essential. Legal discussion around enabling legislation and the delegation role of doctors in supervising PA is necessary. A recruitment process conducted by a professional agency that draws on these historical lessons is essential. Finally, defining roles for PAs and supervisors is considered imperative.

Acknowledgments

The authors would like to express their appreciation to Professor Niki Ellis (Centre for Military and Veterans' Health), Tom Ashman (Physician Assistants Foundation of Canada), Colonel John Chitwood (United States Air Force), Captain James Jones (US Army Medical Department and Interservice PA Program, Fort Sam Houston) and Dr Joshua Tepper (Ministry of Health and Long Term Care of Ontario, Canada) for their valuable contributions to a report authored by Captain Genevieve Liebich (13) that provides the background for this article.

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Table 1. Six types of PA-related activities in the world (8).

State of development	Countries
Development of civilian PA programs	England*, The Netherlands*, Canada*, South Africa, Scotland*, Taiwan
PA-like profession in place	India, Liberia, Haiti, Malaysia
Use of US trained PAs in the national health system	Canada*, England*, Scotland*, The Netherlands*
Hosting workforce developments conferences in which PA profession is proposed	The Netherlands*, England*, Germany, South Africa, Taiwan, China, Ghana
Developing and establishing formal affiliation agreements with USA PA programs for PA student rotation	Brazil, Estonia, United Kingdom*, Ghana, Thailand, Honduras, Ecuador, China, Papua New Guinea, Costa Rica
Seeking information on PA profession	Australia*, Ghana, Ireland, Jamaica, New Zealand, South Africa, Wales.
* Represented at the 35th Annual Physician Assistant Conference of the American Academy of Physician Assistant held in Philadelphia, US, May 26-31, 2007	