The changing physician assistant scope of practice

ABSTRACT
In the 1960s, the profession of physician assistant (PA) rose to prominence and has since transformed the landscape of the medicine by supplementing and supporting the work of overextended physicians. The history of PA practice and its expansion for over a half-century includes many tasks that were once considered the sole domain of physicians. Gradual recognition by medical professionals and lawmakers alike has shaped PA scope of practice to include a wide range of primary, specialty, and subspecialty care, and has the potential to further shape the development of healthcare providers.1

Commentary by Craig A. Baumgartner: This is a thorough and comprehensive history of the PA movement and the effect of the legal system on the development of the profession. Anyone who endeavors to read legal treatises on the PA odyssey will learn a great deal. Such an article should be saved as a reference by all PAs (and healthcare attorneys) for its wealth of legal information. What is especially interesting is that PAs not only have a low incidence of malpractice claims made against them compared with physicians but may actually lower the incidence of malpractice claims made against the PA-physician team. Whether this trend continues as the annual number of new graduates of PA programs increases remains to be seen.2

REFERENCES

Whence primary care docs?

ABSTRACT
The purpose of this study was to calculate the projected primary care physician shortage, determine the amount and composition of residency growth needed, and estimate the effect of retirement age and panel size changes. The National Ambulatory Medical Care Survey was calculated for use of ambulatory primary care services; US Census Bureau data were used to project demographic changes. An assumption used a baseline number of primary care physicians and the number retiring at age 66 years and estimated the annual production of primary care residents. To determine shortages, researchers subtracted the accumulated primary care physician production from the accumulated number of primary care physicians needed for each year from 2015 to 2035. More than 44,000 primary care physicians will be needed by 2035. Primary care production rates will be unable to meet demand, resulting in a shortage in excess of 33,000 primary care physicians. Given current production, an additional 1,700 primary care residency slots will be necessary by 2035. A 10% reduction in the ratio of population per primary care physician would require more than 3,000 additional slots by 2035; changing the expected retirement age from 66 years to 64 years would require more than 2,400 additional slots. To eliminate projected shortages in 2035, primary care residency production must increase by 21% compared with current production. Delivery models that shift toward smaller ratios of population to primary care physicians may substantially increase the shortage.1
Veterans become physician assistants

ABSTRACT

To assess the admission policies, experiences, and attitudes of PA program directors about recruiting, admitting, and training military veterans, a survey was distributed to 173 PA programs. One hundred five programs (61%) responded. The survey covered years 2011 to 2013 and the results were compared with a similar survey of years 2008 through 2010. Veterans were admitted into 88% of responding programs, accounted for 4% of all students, 33% of programs accepted transfer credits for veterans’ military training, and 20% accepted credits for off-duty education. Almost 60% of programs had military veteran faculty members. Active recruitment of military veteran students occurred in 31% of programs. Program directors described multiple benefits of, and barriers to, admitting and educating veterans. More PA programs actively recruited veterans, considered veteran status in the admission process, admitted veterans, contributed to veterans’ financial support, and had an increased percentage of students with military experience matriculating into the program. However, barriers remain for veterans seeking admission into PA programs, the most significant being academic preparedness for graduate-level education.

REFERENCES

Commentary by Scott Shipman: Projections and assertions about the adequacy of the physician workforce are perhaps outnumbered only by critiques pointing to the consistent and sometimes profound inaccuracy of past projections. Petterson and colleagues produce the latest attempt at physician workforce projections, concluding that we will have a shortage of primary care physicians, and need more graduate medical education positions to overcome this shortage. Though methods and scope differ, their conclusions are similar to those released this year by the Association of American Medical Colleges. With every workforce projection, readers must keep in mind that the embedded assumptions drive the outcomes. Therefore, these assumptions should never be less than fully transparent. Most workforce projections share an inability to incorporate the intensely local nature of workforce adequacy. Further, access to care is probably not best measured by the size of the physician workforce. At smaller service area levels, our country has many regions with an abundance of physicians (including in primary care) as well as pockets of shortage. Unless we aim our policies at reducing the maldistribution of physicians, we are unlikely to solve the most vexing problems of adequacy in our nation’s physician supply.

REFERENCES

Commentary by Douglas M. Brock: Historical precedent, workforce demands, social justice, respect for service, and a vast number of healthcare-trained veterans seeking employment support recruiting veterans into PA training. The Affordable Care Act, the Obama Administration’s call to train veterans as PAs, and emerging recommendations to improve outreach indicate that the time is right to examine PA program readiness and willingness to train veterans. Michaud and colleagues have addressed preparedness with a second survey of PA program directors exploring veterans in PA training. Encouraging changes are reported; however, relative inattention and poor understanding of veterans continues. Fewer than one-third of programs actively recruit veterans, and dishearteningly, only about 4% of PA students are veterans. Fewer than 2% of potentially eligible military healthcare-trained veterans even apply for PA training, despite being significantly more likely than nonveterans to be selected for training. Program directors should attend carefully to the implications of these findings, seek an improved understanding of the value veterans offer the PA workforce, and work to build outreach.