

# Physician Assistants in Emergency Medicine

In 1999, the American College of Emergency Physicians (ACEP) surveyed PAs to identify their work environment, postgraduate needs, and the procedures PAs perform. George Molzen, M.D., ACEP board liaison to the task force conducting the survey, concluded that PAs are in emergency departments “side by side with the physicians, picking up the next patient.” The ACEP report showed that patients usually are randomly assigned to PAs (see Chart 1). A high percentage of PAs perform endotracheal intubation and fracture reduction (see Chart 2). A little more than half (52 percent) of the patients seen by the PA respondents are also seen by a physician. The physician in the emergency department rarely or never sees 28 percent of the patients seen by the PAs. Of 700 PAs surveyed, 351 responded.<sup>1</sup> Further findings are detailed in the charts on page 3.

Since the earliest days of the physician assistant (PA) profession in the mid-1960s, PAs have practiced in the field of emergency medicine. Of the estimated 50,000 clinically practicing PAs, 10 percent (5,000) work in emergency medicine.<sup>2</sup>

PAs practice medicine with the supervision of licensed physicians. PAs serve in many aspects of emergency medicine, including pre-hospital patient care, patient triage, fast track, trauma, and selective administrative functions. Their work is not limited to emergency departments. They also provide emergency care for patients in various settings, such as critical care units, pre-hospital situations, and ground or air transport.

## Practice Credentials

PAs are trained in intensive medical education programs accredited by the Accreditation Review Commission on Education for the Physician Assistant. The average PA program curriculum is 26 months. The typical PA student is at least 28 years old, has a bachelor’s degree, and has four years of health care experience prior to admission to a PA program. The programs are offered at medical schools, colleges and universities, and teaching hospitals. There are currently three postgraduate programs for physician assistants in emergency medicine. Postgraduate programs are not a requirement for PA practice.

After graduation, PAs are required to pass the national certifying examination before they can practice. Only graduates of accredited programs may take the exam, which is developed by the National Board of Medical Examiners and administered by the independent National Commission on Certification of Physician Assistants. (Many states provide temporary approval until the new PA graduate takes the next available exam and receives his or her scores.)

To maintain certification — required by some states and many employers — PAs must complete 100 hours of continuing medical education every two years and take a recertification examination every six years. Only those with current certification can use the credentials “Physician Assistant-Certified” or “PA-C.” PAs do not have specialty boards. PAs must apply for and receive state approval (licensure, certification, or registration) before practicing.



Forty-eight states plus the District of Columbia permit delegated prescribing by PAs. Nearly all include controlled substances as part of this authority. All PA educational programs have pharmacology courses. Nationally, 78 hours is the mean number of required hours of formal classroom instruction in pharmacology. Most of the instruction is comparable or identical to that offered to medical students.

## The PA Role

As members of health care teams headed by physicians, PAs provide medical and surgical services that would otherwise be provided by physicians. Each PA's responsibilities depend on the type of practice, his or her experience, the working relationship with the supervising physician, the physician's or institution's decisions about what can be delegated, and state law. Although by law PAs are dependent practitioners, typically they exercise considerable autonomy in clinical decision making. The relationship between the physician and PA is one of mutual trust and reliance. The physician trusts the PA to provide physician-quality care to patients seen by the team and to consult with the physician on those cases that are outside the PA's expertise or scope of practice. The PA trusts the physician to be available for supervision, to provide learned advice, and to accept the care of patients with serious or complex problems.

The Society of Emergency Medicine Physician Assistants (SEMPA) offers guidelines on the role of PAs in emergency medicine.<sup>3</sup> According to SEMPA, PA practice commonly includes, but is not limited to, taking patient histories and performing physical examinations; recording or dictating the information into the patient chart; performing or assisting in the performance of laboratory and patient screening procedures; performing diagnostic and therapeutic studies; ordering and interpreting diagnostic laboratory tests and radiological studies; ordering medications and other therapies; instructing and counseling patients; referring patients to appropriate community resources; and obtaining patient management consults.

PAs working in emergency medicine perform

many diagnostic and therapeutic procedures including, but not limited to, abscess incision and drainage; administration of medications and injections; Advanced Cardiac Life Support; Pediatric Advanced Life Support; analgesia and sedation; anoscopy; arterial puncture and blood gas sampling; arthrocentesis; cast and splint application, removal, and management; central line placement; dislocation reduction management; debridement of burns, abrasions, and abscesses; epistaxis management; extensor tendon repair; foreign body removal; ears, nose, rectum, soft tissue, throat, vaginal, and gastric lavage; Heimlich (small gauge) valve insertion; immobilization (spine, long bone, soft tissue) and transportation; endotracheal and nasal intubations; intraosseous needle placement; simple, intermediate, and complex laceration repair; diagnostic lumbar puncture; nail trephination and removal; nasogastric tube placement and management; ordering and performing initial interpretations of simple plain x-ray films with second reading by supervising physician (or radiologist) for collaboration and correlation with clinical findings; ordering and interpreting EKGs with immediate second reading by supervising physician; paracentesis; regional block anesthesia including double cuff method Bier block; rust ring removal using slit lamp; ocular tonometry; thoracentesis; thoracostomy tube insertion; urethral catheter placement and management; venous access and peripheral cut down; and wound care.

## Hospital Issues

The American Academy of Physician Assistants (AAPA) recommends that when a PA and a physician begin practicing together, they discuss their professional relationship and how they will function as a team. Both parties should understand how they will work together. They should evaluate their practice arrangement on an ongoing basis.

In general, PA practice is not delineated by detailed treatment protocols. Emergency departments may be an exception to the rule, because physicians commonly use protocols and clinical guidelines in emergency practice. When physicians use protocols or clinical guidelines, it is appropriate for PAs to use

them, too. What is not appropriate is defining PA practice by the use of detailed protocols specifically written for PAs. PA education, like physician education, promotes the development of practical skills in clinical problem solving and decision making. It is more practical and establishes better teamwork and communication when the PA and physician work together under a broad practice agreement that allows the PA to exercise his or her clinical judgment while consulting the supervising physician as appropriate and necessary.

## Hospital Privileges

To provide patient care in the hospital, PAs and their supervising physicians must seek delineation of their clinical privileges. The criteria for granting clinical privileges to PAs should be outlined in the medical staff bylaws. The bylaws should include a definition of physician assistant, generally conforming to the definition used in state law and to the general definition of a PA used by the AAPA.

### Sample Definition of Physician Assistant From AAPA:

A **physician assistant** (PA) is an individual who is a graduate of a physician assistant program approved by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies, and/or has been certified by the National Commission on Certification of Physician Assistants (NCCPA). The individual meets the necessary legal requirements for licensure to practice medicine with physician

supervision. (Federally employed PAs need not be licensed, but should meet the graduation and/or national certification requirements.)

PAs should be members of the medical staff. PAs are providers of physician services. They exercise a high level of decision making and autonomy in providing patient care, although they practice as supervised members of physician-directed teams. It is important that PAs participate in the system in which medical care policies are made and communicated.

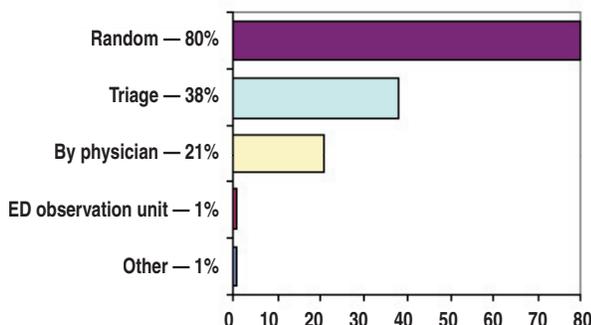
## EMTALA Issues

The Emergency Medical Treatment and Labor Act (EMTALA) touches on PA practice in three main areas: performance of medical screening exams, authorizing patient transfers, and taking call in emergency departments.

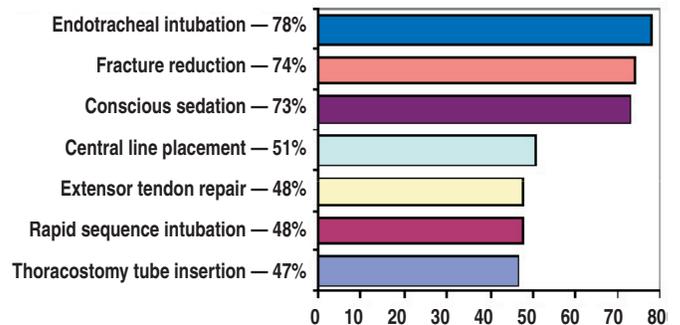
Performing medical screening examinations is a common part of PA practice in an emergency department. The EMTALA law and regulations allow PAs to conduct medical screening exams as long as written hospital policy specifies that PAs are among the providers the hospital deems qualified to conduct them. Individual PAs must be granted authority through privileges or some other mechanism to conduct the exams.

Under EMTALA, a PA may decide a transfer is appropriate and sign the transfer order sending a patient to another hospital, with two caveats. The PA must consult a supervising physician before the transfer is made, and the physician must countersign the PA's order within a reasonable period of time,

**Chart 1 — Patient Assignment Method to PAs in Emergency Medicine (PAs were asked to check all methods that apply to their situation)**



**Chart 2 — Percentage of PAs in Emergency Medicine Who Conduct Select Procedures**



according to hospital policy.

The original EMTALA law and the regulations, produced by the (then) Health Care Financing Administration in June 1994, were silent on the question of whether physicians could delegate emergency room call to PAs. They said simply that hospitals must maintain on-call lists of physicians. In response to AAPA requests for clarification, the Centers for Medicare and Medicaid Services (CMS) clarified the authority of physicians to delegate call to PAs in the September 9, 2003, *Federal Register* (page 53256). In May 2004 interpretive guidelines, CMS further stated: "The decision as to whether the on-call physician responds in person or directs a non-physician practitioner (physician assistant, nurse practitioner, orthopedic tech) as his or her representative to present to the dedicated ED is made by the responsible on-call physician, based on the individual's medical need and the capabilities of the hospital and applicable state scope of practice laws, hospital bylaws, and rules and regulations. The on-call physician is ultimately responsible for the individual regardless of who responds to the call."

## Reimbursement

Medicare covers medical services provided by PAs at 85 percent of the physician fee schedule. Medicare makes no distinction among the hospital inpatient, outpatient, or emergency department settings, and generally allows PAs to deliver the same services that physicians provide in the hospital setting (within the PA's scope of practice as determined by state law) using the same Current Procedural Terminology (CPT) codes.

Medicare follows the PA regulations established in each state regarding the degree of physician supervision required in hospitals. Under Medicare's guidelines, the physician supervisor need not be physically present with the PA in the hospital when a service is being performed unless specifically required by state law or by the hospital's regulations.

It should be noted that "incident to" billing was never intended for use in hospitals or emergency departments.

## Other Resources

American Academy of Physician Assistants, 703/836-2272, [aapa@aapa.org](mailto:aapa@aapa.org), [www.aapa.org](http://www.aapa.org).

Society of Emergency Medicine Physician Assistants, 703/519-7334, [info@sempa.org](mailto:info@sempa.org), [www.sempa.org](http://www.sempa.org).

## Useful Web Links

- AAPA, PAs in Emergency Medicine Issue Brief: [www.aapa.org/gandp/emergency.pdf](http://www.aapa.org/gandp/emergency.pdf)
- SEMPA, Frequently Asked Questions: [www.sempa.org/emfaqs.htm](http://www.sempa.org/emfaqs.htm)
- AAPA, PAs and EMTALA, Frequently Asked Questions: [www.aapa.org/gandp/emtala-faq.html](http://www.aapa.org/gandp/emtala-faq.html)
- AAPA policy, Guidelines for Amending Medical Staff Bylaws: [www.aapa.org/gandp/bylaws.html](http://www.aapa.org/gandp/bylaws.html)
- AAPA, Third-party Payment Issues: [www.aapa.org/gandp/3rdparty.html](http://www.aapa.org/gandp/3rdparty.html) and <http://www.aapa.org/gandp/reimburs-issues.html>
- AAPA, Resources for Employers: [www.aapa.org/joblink/employers.html](http://www.aapa.org/joblink/employers.html)

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## References

1. Hughes N. "ACEP Survey Provides Statistical Information on Utilization of PAs in Emergency Medicine." *AAPA News*. November 1999;20(20):1.
2. 2003 AAPA Physician Assistant Census Report. American Academy of Physician Assistants. Alexandria, Virginia. October 6, 2003.
3. SEMPA Guidelines for the Utilization of Emergency Medicine Physician Assistants. May 24, 2003.



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