

The Utilization of Physician Assistants in Canada
An Environmental Scan

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Physician Assistants An Environmental Scan

Summary

The demand for an alternate healthcare provider with the knowledge and skill to undertake delegated medical services and relieve the burden on licensed physician, appears to be growing as healthcare administrators in North America, Britain, India and Australia struggle to manage the increasing demand for medical care. In the US, physician assistants have been filling this void for the past 30 years. There are currently over 55,000 physician assistants working in all areas of the healthcare system and the profession is expected to be one of the fastest growing in the US through 2010, exceeding the growth among physicians.

The experience with physician assistants in Canada has been quite different than in the US. The Canadian military has utilized physician assistants for many years but within the past 5 years, more healthcare administrators in the civilian sector, faced with long waiting lists and medical manpower shortages, have begun to utilize a variety of healthcare professionals as “physician extenders”. A few are trained physician assistants but the majority are international medical graduates who work under the supervision of a physician in specialty care areas of tertiary hospitals. For the most part, provincial and territorial governments and regulators have remained silent about the utilization, training, regulation, remuneration, and potential duplication of service with other healthcare professionals. At the same time, the move to introduce and train more physician assistants seems to be gaining momentum.

INTRODUCTION

DEFINITION: A Physician Assistant is a health care professional licensed to practise medicine under the supervision of a licensed physician.

The volume of literature about physician assistants (PA) is surprisingly large, given the short period of time these healthcare providers have been around. Most of the literature is from the US and focuses on the history, growth and scope of practice of the profession, statistical reports and opinion/ position papers. There is however a small body of research about the efficacy and patient satisfaction as well as predictors of success in PA programs in the US.

This paper will discuss the development, education and regulation of Physician Assistants in the US, provide a brief overview about the utilization of PAs in other countries and review the current status for physician assistant utilization in Canada, including the challenges and opportunities for policy makers to consider in the growing debate about the inclusion of physician assistants in the healthcare team. The material for this paper was compiled between January-April, 2005 from a review of the literature and interviews with key informants.

THE GROWTH OF THE PROFESSION

The first mention of physician extenders in the literature originates from Germany where the military used “felders” as medical assistants. Peter the Great introduced “medical assistants” into the Russian military in the 17th century and China utilized over 1.3 million "barefoot doctors", an early iteration of the PA, to improve the delivery of health care in the 1960's. However, the predominant and sustained growth of the PA profession has occurred in the US.

THE US EXPERIENCE

The history and evolution of Physician Assistants (PA) in the U.S. is well documented. PAs were introduced in the mid 1960's to address the nationwide shortage and maldistribution of doctors in primary care and to increase access to health care for people in underserved areas. Medics trained as first responders in the Viet Nam War provided a “ready made” supply of providers who were seeking opportunities to utilize their skills.

Education programs to train for PAs were also introduced in the US in the mid 1960's. In 1967, the University of Alabama in Birmingham, initiated a surgeon's assistant program and the following year, the first baccalaureate degree program for PAs was started at Alderson-Broadus College in West Virginia. By 1971, the US government was providing funding to expand the PA training programs and the American Medical Association started work on national certification and codification of PA practice.

characteristics. That same year, the American Association of Physician Associates published its first official journal, the *Physician's Associate*. (Pace, R; Cohen,S, 2003).

PAs are now a major component of the healthcare system in the US. As of January 1, 2005, there were 55,061 PA working as part of a health care team in virtually every clinical service: primary health care, emergent, and specialty care in medical and surgical practice settings.(2004 Census from the American Association of Physician Assistants).

The Physician Assistant Strategic Planning Group in the US and the Federal bureau of Labour Statistic in the US predict that the PA profession will be one of the fastest growing in the US through 2010, exceeding the growth among physicians.(Isberner, 2003; Communications, 1999). While estimates on the growth of the profession vary, the number of practising physician assistants is projected to reach 53,200 by 2005 and 79,000 by 2015 (Cooper, 1998).

Table 1: Characteristics of the Physician Assistant Workforce, 2004

Descriptor	Percent
Sex:	F-60%; M-40%
Age	Mean age is 42
No. of Years in practice	Mean number is 9.2, median is 6
Hours of Work /week(for FT workers)	Mean is 44.4 hours/week, median is 42 hours/week
Hours of on call	39% take oncall. Mean hours on call/month is 99
Annual income	Not self employed-\$74,262 (In 2003, \$64,536)

(Source:2004 AAPA Census)

Scope of Practice

In general, PAs see the same types of patients as a physician but generally, patients seen by a PAs generally require more routine and straightforward care. As part of a physician directed team, PAs perform generic tasks such as taking medical histories, conducting physical exams, making a diagnosing and treating illnesses, ordering and interpreting tests, counseling on preventive health care, assisting in surgery, making referrals and in many states writing prescriptions. Forty-eight states, the District of Columbia, and Guam have now enacted laws that authorize PA prescribing. Representatives from the American Academy of Physician Assistants (AAPA), the Association of Physician Assistant Programs (APAP), the Accreditation Review Commission on Education of the Physician Assistants (ARC-PA), and the National Commission on Certification of Physician Assistants (NCCPA) are developing a joint working statement to define PA competencies. (This should be available late 2005). It is important to note that not all PAs perform all tasks and activities. Activities performed by the PA are subject to government legislation and regulations, the policies of the PA's employer, and, most importantly, the

direction of the supervising physician. Specialized procedures (eg, insertion of central access lines and chest tubes, invasive diagnostic procedures, ambulatory surgery) performed by physician assistants are specific to a particular clinical field or setting, not unlike those undertaken by physicians and are commensurate with adequate formal or informal postgraduate training.

The 2004 AAPA Census Report identifies hospitals as the “primary” work setting for PAs. However, many PAs are working as primary healthcare providers in satellite and rural clinic and physician offices, often where there is no physician on site.

Table 2. Workplace Setting for PA, 2004

Workplace	Percentage
Hospital	37%
<ul style="list-style-type: none"> • ERs • Inpatient Units • Outpatient Units • OR 	<ul style="list-style-type: none"> • 10% • 9% • 8% • 7%
Physician Group Practice	29%
<ul style="list-style-type: none"> • Single specialty • Multi specialty 	<ul style="list-style-type: none"> • 20% • 9%
Physician Offices	13%
Community Health Facilities	8%
Other	13%

(Source: 2004 Census, AAPA).

The Intergration and Acceptance of PAs into the Health Care Team

The demand for PAs is directly proportional to the demand physicians make for them. For physicians, interest in PAs comes down to what the perceived value of that professional is and what “value added” the PA will provide to the practice. Benefits cited by physicians include decreased workload, increased productivity for physicians, improved quality of care, decreased patient wait times, better patient education and cost effectiveness. (Isberner et al, 2003). Ninety one (91%) of the 2004 Census respondents reported seeing 96.0 outpatients per week (mean number). One-third of respondents who work full-time (33%) who see inpatients in their primary job, provide 61.8 patient encounters (mean number) per week (.2004 Census, AAPA).

HMOs (Health Maintenance Organization) in the US recognized early on that using PAs could be cost effective .as most physician assistants in primary health care settings can provide 80% or more of the services provided by a physician at the same level of quality. At the same time, the average salary of PAs working full time in primary care is significantly less than the salary for a primary care physician for providing the same care.

In one of the few rigorous economic studies of physician assistants, Grybicki et al (2002) compared the economic benefits of the daily practice of a PA in a family/general medicine practice in California to similar practices that did not use PAs. In this study, PAs saw an average of 18 patients per day whereas physicians saw between 17-27 patients per day depending on the complexity of each patient encounter. These statistics are close to national means. They found that the salary differential between the PA and the physician was one of the major factors impacting the economic benefit of using a PA. The authors do caution however that as salaries vary with experience, population served and amount of oncall, cost effectiveness will vary and/or decrease. The Pew Health Professions Commission also noted that as the salary differential between primary care physicians and PAs in the US narrows due to physician oversupply, some care delivery systems may see less value in hiring a PA.

The quality of care provided to patients has been identified by physicians as an essential element of the physician acceptance of a PA into a practice. Loss of continuity with patients and concern that PAs overstep their boundaries were also cited as concerns. (Isberner et al,2003,). A study of emergency room care, Kaups et al (1998) found that no difference in the level of competence between the PA, resident and attending physician. Millar et al (1998) also found marked improvement in outcome measures after the introduction of PA in the ER. Transfer time to OR decreased by 43%, transfer time to intensive care decreased by 51%, and transfer time to hospital units decreased by 20%.

Patient surveys and studies also report satisfaction with the care received by PAs including quicker appointments, better attention to patients and follow up care. However most of these are based on anecdotal reporting. A survey completed by Hooker et al (undated) evaluated the satisfaction level identified by patients with a variety of providers. They found that patient satisfaction with care appears to depend more on the communication skills and style of the provider, not on the type of provider. A remarkable similarity exists in care as perceived by patients of PAs, nurse practitioners and physicians when measured at the same time in the same setting.

Educational Requirements

Competition for PA training position in the US is intense. In 2001, there were five applications for every place offered in the training programs. Currently in the US, 135 entry level programs have been approved by the Accreditation Review Commission on Education of Physician Assistants (ARC-PA).

The 2004 AAPA statistics indicate that over 91% of applicants applying to the PA programs have a university degree prior to entering PA training. The majority of students accepted into PA programs have approximately 45 months experience working in the health care system prior to admission to the training program, an element that educators state is a very important indicator for successful attainment of competency as a PA. The degree awarded at the completion of training is quite varied. Fifty percent (50%) of the PAs graduate with baccalaureate PA degrees while twenty-two percent (22%) receive masters PA degrees. Currently there are 87 master's degrees or a master's degree option,

50 bachelor's degrees or a bachelor's degree option and 6 associate degrees programs in the US. There are also 50 programs that offer only a certificate of completion. (AAPA, 2004). Only about 2 percent of respondents to the AAPA survey hold a doctoral degree. As with other healthcare professional disciplines, "degree creep" is an issue. The University of North Dakota administration advises that many of PA programs in the US are in the process of moving to a Masters degree with a prior baccalaureate degree required as a minimum entry. (Brown, 2004).

PA education programs are modeled on the training physicians receive. The typical PA program is 24-27 months long with 1 year classroom and laboratory instruction in the basic medical and behavioral sciences (such as anatomy, pharmacology, pathophysiology, clinical medicine, and physical diagnosis), followed by clinical rotations in internal medicine, family medicine, surgery, pediatrics, obstetrics and gynecology, emergency medicine, and geriatric medicine. Educational programs are certified by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) (At this time, there is no national approval process for Master's programs).

Upon graduating, physician assistants write the Physician Assistant National Certifying Examination (PANCE). The exam was developed by the National Commission on Certification of Physician Assistants (NCCPA). Only candidates who have graduated from an accredited PA program are eligible to take the exam. All states require passage of the PANCE for state licensure but forty-six states do permit new graduates to practice prior to passing the PANCE.

Once certified, the PA must complete a continuous six-year cycle to maintain certification. In addition, they must earn 100 approved CME hours, reregister their certificate with the NCCPA (second and fourth years), and by the end of the sixth year, recertify by successfully completing either the Physician Assistant National Recertifying Examination (PANRE) or Pathway II.

Regulatory

PAs are licensed in 43 states by their state Medical Board. The Medical Board rules define the medical functions a PA may perform under the supervision of a licensed physician. Requirements for licensure as a physician assistant include:

- Graduation from an approved physician assistant program
- Verified practice history
- Passage of the NCCPA National Board Exam
- Verification of Federation of State Medical Boards disciplinary history

Three (3) states regulate PAs and 5 require only proof of certification (2004 Census, AAPA). In those 8 states (where licensure is not required), PAs must still meet the same requirements as a "licensed" PA and practice under a supervising physician. The American Academy of Physician Assistants (AAPA) recommends licensure for all PAs

and is encouraging standardization of terminology describing PAs. From a legal perspective, the AAPA is concerned that many laws defining practice apply only to “licensed” practitioners, thus exempting unlicensed PAs.

In addition to state medical boards, there are multiple organizations that oversee the profession.

- The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) protects the interests of the public and PA profession by defining the standards for PA education and evaluates PA educational programs within the United States to ensure their compliance with those standards.
- The National Commission on Certification of Physician Assistants (NCCPA) is the credentialing organization for physician assistants in the United States. Established as a not-for-profit organization in 1975, NCCPA protects the public by assuring that certified physician assistants meet established standards of knowledge and clinical skills upon entry into practice and throughout their careers. Every U.S. state, the District of Columbia and the U.S. territories rely on NCCPA certification criteria for licensure or regulation of physician assistants..
- The Association of Physician Assistant Programs (APAP) is the national organization in the United States representing physician assistant (PA) educational programs. APAP’s mission is to pursue excellence, foster faculty development, advance the body of knowledge that defines quality education and patient-centered care, and promote diversity in all aspects of physician assistant education.
- Lastly, the American Academy of Physician Assistants (AAPA) is the only national professional society represents all physician assistants in every area of medicine. It has 57 chartered chapters in 50 states, the District of Columbia, Guam, and the federal services. Their mission is to promote quality, cost-effective, accessible health care, and to promote the professional and personal development of physician assistants. They also collect and analyze data to track the growth and changes in the physician assistant profession. The data are collected from various projects that are maintained throughout the year by the AAPA Division of Data Services and Statistics. The most important of these activities is AAPA's Annual Census Survey of PAs.

OTHER COUNTRIES

There is little written material about PA training programs or utilization in other countries. India, Netherlands, Malasia, Liberia, Haiti, Lesotho, Thailand, Canada, South Africa and Great Britain are currently utilizing “physician extenders” in a range of healthcare settings and Australia is considering the adoption of the physician assistants

In 2001, the College of Physicians and Surgeons in Great Britain released a report, [Skill Mix and the Hospital Doctor; New Roles for the Health Care Workforce \(2001\)](#) that

recommended the introduction of a new healthcare practitioner to relieve the pressure on physicians. A pilot program to train physician assistants to work in Primary Health Care in London was scheduled to start September 2004.

An online search identifies masters programs for physician assistants offered in Chennai India and by the British Council UK, USA, and IDP Education Australia. However, details about these program information could not be found.

THE CANADIAN EXPERIENCE WITH PHYSICIAN ASSISTANTS

The Canadian experience with PAs has been very different than in the US. In Canada, the Canadian military and some employers utilize physician assistants in the traditional capacity referred to in the introduction. However, in the past 5 years, more and more professionals working under a range of titles, but performing functions similar to that of a PA, have been added to Canadian hospital healthcare teams. The terminology used to describe these professionals can be confusing. The use of the term “physician extender” is used more generically to include any provider who performs medical diagnosis and treatment under supervision or delegation of function from a licensed physician. Several jurisdictions use registered clinical assistants, who may perform in the same capacity as a physician assistant or who may have a scope of practice more similar to a house medical officer or medical resident. Advance practice nurses working as first assistants (RNFA) are sometimes included in the description of physician extenders but have not been included in the discussion in this paper. For the most part, these nurses are licensed by their nursing associations and work under nursing management undertaking delegated medical functions. However, the contribution of these practitioners to the healthcare team is very important to consider in the policy discussion about physician assistants.

For over 3 decades, the Canadian military has trained PAs to work in their clinics and hospitals. There are approximately 150 positions for PAs in the military although many are vacant. In addition to the military positions, there are about 40 trained/licensed civilian physician assistants or physician extenders in equivalent positions. The latter group, “physician extenders” is more eclectic and appears to be growing quickly, particularly in western Canada. For the most part, physician extender positions are filled primarily with international medical graduates who work in carefully supervised environments, primarily in specialty care areas of tertiary hospitals, providing medical care normally managed by residents or house officers. There is anecdotal information that private industry in Canada may also be turning more to physician assistants to provide medical services. For the purposes of this discussion, nurses who provide medical care under delegated function policies are not included under the physician extender definition.

Health care managers in Canada point to the medical manpower shortage across Canada as well as the changes to the resident training programs and contractual agreements restricting the hours of work for residents as the primary reasons for the introduction these “alternative or complementary” providers to the health care team. Unlike the US,

where PAs generate income for HMOs, the addition of physician assistants/ physician extenders represents an attempt to manage the increasing demands for patient care that cannot be filled by the traditional providers.

Provincial/Territorial Policies Regarding Utilization of PAs

Government representative, medical regulatory bodies and key informants were asked to provide information regarding the regulation and utilization of PAs/physician extenders/clinical assistants in their province or territory. As noted in the introduction to this section, the professional designation or title varies from jurisdiction to jurisdiction although the work performed by these providers is similar. What is striking about the provincial/territorial information is the lack of recognition and even awareness of these alternate healthcare providers by health officials despite reports from employers that they are being employed in some capacity in many jurisdictions.

At this time, only two provinces, Manitoba and Alberta, officially utilize registered clinical assistants (RCA). In Manitoba, the only province with legislation to approve clinical assistants, the Winnipeg Regional Health Authority employs 14 RCA in their tertiary hospitals. Twelve (12) of these are international medical graduates and 2 are trained in other health disciplines. The Health Authority has hired a PA recruiter to fill another 6 positions and there are discussions underway to utilize a RCA in a rural primary healthcare setting.

Alberta utilizes Clinical Assistants but their scope of practice is somewhat different than RCAs in Manitoba. The Clinical Assistants in Alberta work under the supervision of a physician but their scope of practice is closer to that of a hospitalist or house medical officer. In Calgary, all clinical assistants are international medical graduates (IMGs) who have been assessed by the Alberta IMG programs to be “resident ready”. Only those eligible for the Alberta IMG program are considered for these positions. The director of the Clinical Assistant program in Calgary indicated he sees the utilization of clinical assistants in the current role as temporary. With the increase in enrollment in medical schools, he feels that within 5 years, there will be sufficient residents to undertake the tasks now done by the Clinical Assistants. In Edmonton, the Clinical Assistants are also IMGs but they are selected following a 4 month assessment/orientation program. IMGs working in this restricted practice environment, work under a special license by the Alberta College of Physicians and Surgeons.

The Justice department in Nova Scotia has engaged a private company, PRAXES, to provide medical staff in the provincial correctional facility. PRAXES employs 4-5 PAs who provide on-site medical care at the correctional facility from 1900h -0700h daily. They are all Department of National Defence trained PAs While recognizing that the absence of licensure is an issue that must be addressed, the correctional authority and the employment agency, PRAXES, feel that the benefits of using well qualified PAs outweighs the risks of not filling the positions or filling them with other less qualified healthcare professionals.(*personal communication with Susan Halliway, PRAXES*)

For the most part, the provincial/territorial Ministries of Health have either no official position or no plan to include PAs as part of their healthcare teams. Newfoundland debated the issue several years ago and rejected it. Nova Scotia has prioritized Nurse Practitioners. New Brunswick reports no immediate plans to utilize them although they might reconsider this position in the future. Ontario and British Columbia all reported no “official” position on the introduction of PAs in their jurisdiction at this time. Manitoba utilizes them but has no official position on expanding their utilization. Saskatchewan has not plan to include them, priority is being given to nurse practitioners. Yukon is open to the concept of physician assistants and has an Act under which regulations could be implemented. However, this is not a priority for them at this time. Other Ministries of Health did not reply to the request for information.

Table 3 presents the positions of the Medical Regulatory Colleges. As medical is a self regulated profession and PAs practice under the license of a practicing physician, their position must be considered carefully.

Table 3. Positions of Medical Regulatory Colleges on Utilization of Physician Assistants 2005

PROVINCIAL REGULATORY RESPONSES – PHYSICIAN ASSISTANTS	
Province *	Reply
Newfoundland / Labrador	No legislation covering the regulation of Physician Assistants. PA is reserved for the non medical assistant trained by DND. Clinical assistants are physicians with limited licensure who assist on hospital wards. The Board has considered PAs but there is no authority in the current medical act to regulate non MDs
Prince Edward Island	No regulations governing physician assistants.
New Brunswick	With the possible exception of those in the military, of which we have no direct knowledge, they remain an unknown breed here. Very different from the US. Nor do I suspect that will change. Political forces seem to suggest any such physician "extenders" will likely come through the nursing stream.
Nova Scotia	Non-physicians (non-MDs) as assistants are not licensed in NS. IMGs have been licensed for over 10 years as Clinical Assistants at the QEII Health Sciences Centre. They act in the capacity of residents under supervision and receive a Defined License specifically to work at the QEII under the sponsorship and direction of the Dept Head. The requirement is graduation from a medical school in the FAIMER directory, a pass on the MCCEE, and a contract with the QEII. There have been Clinical Assistants in gastroenterology, hematology, bone marrow transplantation, radiation and medical oncology, cardiology, rheumatology, physical medicine, orthopedic surgery etc.
Québec	There is no licensure or recognition of any physician's assistant. Concerning nurses, legislation revised our Code of professions in 2003 opening the sharing of some medical procedures with other professionals (the so-called "Law 90". Three nursing specialties are now being developed in three areas: neonatology, nephrology and cardiology. Other areas are being explored for the future, including, pneumology and psychiatry.
Ontario	We do not have a registration category for physician assistants. Political discussions around this issue are underway in Ontario. "College urges government to consider that, due to changing practice patterns; the provision of primary health care may incorporate providers in addition to family physicians or general practitioners." (From "Tackling the Doctor Shortage" CPSO discussion

	paper May, 2004
Manitoba	<p>MB is the ONLY province with legislation to approve Clinical Assistants. In MB, they may be any graduate of a WHO accepted medical school, any member of a regulated health profession in MB or an emergency medical tech at the highest level [Level 3]. They are non-certified CA's and must have immediate oversight of their practice by the supervising physician.</p> <p>We also accept a registered US PA or a PA certified by the Canadian Forces. These individuals are permitted to practice in a different site from the Practice Supervisor.</p> <p>The license is a specific register under the medical act called Clinical Assistant Register Part II [as opposed to Part I which is the Educational Register].</p>
Saskatchewan	<p>In Saskatchewan we do not register and/or regulate any non-physicians as physician assistants. Both the Saskatoon and Regina Health Regions engage physicians to work as "critical care associates" in the five major teaching hospitals in this province. Their practices are limited to these teaching hospital settings and must qualify for licensure under one of our standard licensure categories (Temporary, Provisional, or Full).</p>
British Columbia	<p>BC has no provisions, whether legislative or policy based, which pertain to physician assistants. The BC Legislature, the Registered Nurses Association of BC and ultimately, this College, are currently dealing with the concept and qualifications of Nurse Practitioners. The first class will be graduating this summer and the scope of practice and level of responsibility of Nurse Practitioners is currently being defined.</p>

(Information provided to Dr Ian Bowmer, Health Canada, March 2005).

Standards and Scope of Practice

The Canadian Association of Physician Assistants (CAPA) is the very active governing body for physician assistants. They have 5 chapters across the country. CAPA currently operates under the auspices of the Canadian military but the organization is in the process of incorporating as an independent body and will become the national certification body, responsible for the certification of all PAs in Canada, not just those in the armed services. As such, CAPA will set the standards for certification, maintain records of competency and records of completion from accredited educational programs for all PAs. Anticipating the growth of the profession and the acceptance of PAs as part of healthcare team in Canada, CAPA has also developed scope of practice guidelines, an occupational competency profile (CAPA, 2001) and a certification examination for graduates of their program. On February 17, 2005, 22 applicants wrote the first certification exam.

In May 2003, The Canadian Medical Association (CMA) recognized the PA as a designated health science profession and agreed to become the accrediting body for PA educational programs in Canada. (Brown, 2004). The CMA Committee on Conjoint Accreditation conducted its first accreditation visit and approved the Canadian military program in June 2004

The College of Physicians and Surgeons of Manitoba is the only jurisdiction in Canada to officially license RCA) as a separate professional group under the Medical Act. Under the act, healthcare professionals, either international medical graduates or other skilled healthcare professionals applying for the positions must meet the requirements set out by and College, have a job offer and demonstrate competency to perform the functions

outlined in their job description. For about 4 years, the University of Manitoba Faculty of Medicine has offered a 3 day competency assessment examination, using an OSCE (Objective Structured Clinical Examination) format, that is based on the generic job description for a RCA. The cost of the testing is \$1500. Manitoba utilizes registered clinical assistants (RCA) exclusively in specialty care areas in the two tertiary care hospitals in Winnipeg although there are discussions about introducing a RCA into a northern primary healthcare setting as well as into the Emergency department in a rural health authority.

Training Programs in Canada

Canadian Military Program

At this time, the Canadian military offers the only one training program in Canada. In 1992, they made changes to their program to model it after those in the US programs, In September 2002, the Canadian Forces Medical Service School (CFMSS) was reconstituted as the Canadian Physician Assistant Program (CPAP). Entry is restricted to those with paramedical training, rank of sergeant and 8-10 years of experience. The current CPAP course curriculum offers 12 months didactic/laboratory at Canadian Forces Base (CFB) Borden, Ontario and 47 weeks supervised clinical rotations. In 2003-04, the clinical training component of the military program was offered by the University of Manitoba Faculty of Medicine. The Canadian Forces Trauma Training Centre West (CFTTC(W)), located at the Vancouver Hospital and Health Sciences Centre - Vancouver General Hospital (VGH) also provides clinical training in trauma management for PAs.

Civilian Training

There are no physician assistant programs for civilians in Canada. Two educational facilities are however, considering the introduction of a civilian PA program. The University of Manitoba Faculty of Medicine is one of those facilities. A feasibility study outlining the options for offering a PA program has been submitted to the Dean of Medicine for his consideration. The faculty has some experience with the CAPA program as they provided clinical rotations for the Canadian military program in 2004. It is interesting to note that the University of Manitoba website offers career counseling information for those interested in training as a PA although the site does indicate students must attend an American program at this time.

The Justice Institute of British Columbia has submitted a proposal to the BC Ministry of Education to offer a joint program with the University of Washington that will train 12-24 PA students starting in the fall, 2006. Applicants will complete 12 months of the didactic studies at the MEDEX Northwest, a Physician Assistant program at the University of Washington and return to BC to for the second year of clinical training. Tuition is estimated to be \$27,000 year. Upon graduation, the PAs are expected to work in primary healthcare settings in underserved areas in BC. The University of Washington was chosen not just because of its close proximity to BC but because it is

one of the oldest training programs in the US and has a program designed to assist aboriginal people to be mentored and trained as PAs. As the aboriginal community is one of the targeted user of PAs, Dr Sun, a consultant to the program development committee, indicated that this program is of particular interest to the Assembly of First Nations as well as many BC employers who have not been able to fill physician / nurse practitioner positions in their communities. Some potential employers have indicated willingness to pay the tuition for students with a condition they work for them after graduation. At this time, government funding for the program has not been approved. Although the program has not been approved, students will find an announcement about the program and can apply for application packages on the Medex website. (www.washington.edu/medicine/som/depts/medex).

Remuneration

In Manitoba, the salary scale for PAs, whether they are IMGs or licensed healthcare providers, is between \$60-75,000 per annum. In BC, the salary anticipated for PA is between \$50-70,000 although there are PAs currently working in the north who are paid \$85,000/annum. The Director of the Clinical Assistant program in Calgary reports that the remuneration for clinical assistants is closer to the Manitoba level but in Edmonton, they receive \$3500/month during the assessment and once hired into a permanent Clinical Assistant position, their pay is equivalent to that of a family physician. The PAs in working in the correctional facilities in NS are paid \$33 hour. Specific information about remuneration for PAs in the military was not available but the salary appears to be linked to the rank of the PA.

The level of remuneration was identified by the PA recruiter in Manitoba, as a major challenge to recruiting. PAs from the US. The pay scale in the US and the opportunity to generate more income by seeing more patients, is significantly greater. However, it should be noted that PAs in the US are often used by HMOs to generate income whereas in Canada, they are intended to relieve the stress on the system.

In Canada, the majority of family practitioners still work in a fee for service environment. This is proving to be another barrier to the introduction of PAs to physician offices. Most collective agreements between the physicians and the governments do not permit third party payments for medical services. In other words, the physician must actually see the patient and perform the procedures in order to bill provincial healthcare plans, thus eliminating any potential benefit of introducing an extender into the practice team.

CHALLENGES AND OPPORTUNITIES

The need for an alternate healthcare provider to manage the demands of the healthcare system has been debated for many years. Most provinces and territories have made a major investment in supporting the expansion of nurse practitioner roles. This must be a major point of discussion for policies makers in their consideration to expand the

utilization of physician extenders. However, with the declining number of medical graduates choosing family medicine as a career, the disappearance of the generalist specialist and the increasing crises in rural healthcare, the introduction of physician assistants/ physician extenders/registered clinical assistants may represent another opportunity to address many of the chronic problems faced by the healthcare system. The energy and support driving the move to introduce physician assistant in Canada is remarkable and suggests that health policy makers need to carefully and proactively examine the scope of practice, feasibility and benefits of utilizing physician assistants before the issue become uncontrollable.

Development of a Policy Framework

In the absence of a clear policy framework, discrepancies about scope of practice, the standards for practice and qualifications will continue to grow, leading to public confusion, professional wrangling and unhealthy competition between the jurisdictions.

The debate regarding utilization of Nurse Practitioners(NP) versus PA cannot be avoided. While it is hoped that physicians, nurse practitioners and physician assistants can and will complement the care provided by the other, the overlap in the scope of practice of each professional cannot be ignored. The literature suggests that professional overlap is a non issue. The American College of Nurse Practitioners (ACNP) notes “NP’s focus largely on health maintenance, disease prevention, counseling, and patient education in a wide variety of settings.” In contrast the primary focus of the physician assistant is to diagnose and treat medical conditions in a tightly controlled environment.

Less debated but no less significant is the potential for duplication of function between physicians and PAs. CAPA and the AAPA clearly state there is no conflict of interest as the PA works under the supervision of a physician, completing only the tasks delegated by the supervising physician. Ensuring that physicians are onside and understand the role of the PA will be critical

The policy debate must also include discussions about standardization of titles, licensure and education. There are a number of models for licensure that could be considered, including licensure as a self regulating profession, licensure as a substrate of another profession (Manitoba model) or applying licensure conditions to the supervising physician’s license. As many provinces are pursuing Omnibus legislation for healthcare providers, there may be an opportunity to develop a consistent approach to licensure for PAs across the country and avoid the problems of inconsistent licensure requirements currently encountered by provincial/territorial physician and nursing regulatory bodies.

Remuneration policies must also be resolved. Governments may find it advantageous to introduce more salaried providers into the system. However, it is unlikely that many governments will want to increase the size the their medical remuneration funds. Regardless of whether PAs are paid from the fee for service or alternate payment funds, it will likely require a significant increase in the medical remuneration budget. The issue of paying physicians to supervise PAs has also been raised as a remuneration issue.

Identifying the Cost Benefits to Introducing PAs.

Part of any policy discussion is a cost benefit analysis. The introduction of new educational programs in Canada, as well as remuneration for a new provider group will be expensive and require new funding from governments. At a time when most provincial government budgets are strained, this expense must be balanced against competing priorities such as increasing enrollment in medical schools and nurse practitioner programs and an analysis of the cost efficiencies that can be achieved by introducing this category of provider.

However, the potential benefit for PAs in providing medical services to underserved populations cannot be overlooked. The challenge of providing appropriate healthcare to rural and remote parts of Canada has challenged policy makers for years. Over the years, a number of solutions have been offered-develop rural medical education programs, introduce nurse practitioners, recruit rural students into professional programs etc. Several of these programs, such as the northern medical education site in Prince George, the expansion of nurse practitioner training in Ontario, the introduction of the aboriginal midwifery program in Manitoba are underway but it will be some time before the results of the initiatives are evident. When PAs were introduced to the US healthcare team in the 1960's, it was thought their primary benefits would be provision of primary care in underserved areas of the country. For a variety of reasons, only about one quarter of PAs in the US are employed in areas with populations of less than 50,000 (Isberner et al, 2003). There is nothing to suggest that the Canadian experience would be different. In fact, Canada's underserved communities pose even greater challenges in that they are smaller and more remote. There has been a suggestion that Emergency Responders could be utilized more effectively in rural communities, perhaps doubling as physician assistants in the local hospitals and clinics. This may a reasonable option to consider.

Finding and retaining healthcare practitioners in aboriginal communities is a continued challenge for the federal government. The Assembly of First Nations has expressed interest in promoting the utilization of PAs in their communities and training First Nation people as PAs. They feel that a program that is 2 years in length, one year of which can be completed in their community, offers an obtainable goal for many aboriginal people and will address the issue of retention and sustainability.

Identifying New Funding

Even if there are benefits to introducing physician assistants into the healthcare team, it will be expensive and require new funding for educational programs and salaries. Salaries for PAs in Canada are between \$50,000 to \$75,000. In the US, many PAs make over \$100,000/year. There has been a suggestion from some advocate and employer groups that physician fee for service funds could perhaps be redirected. However, it is unlikely that this would be acceptable to the physicians. As well many provincial medical insurance plans have no provision to redirect payment to non physicians or third parties.

Already in Canada, there are discussions about establishing PA education programs. Initially, the number of programs is likely to remain small and collaborative educational models should be explored. Although education falls under provincial jurisdiction, there may be a role for the federal government to broker the development of collaborative programs, given the current investment of the Canadian military, the federal responsibility for providing healthcare for aboriginal communities and federal correction facilities.

It is very expensive to establish a new professional group. CAPA has been established as the organization that will develop and monitor standards, develop competency examinations and maintain records of practitioners- all very expensive activities that will require financial support.

Loss of opportunity for international medical graduates

Many IMGs view the opportunity to work as a clinical assistant as an important entry point for licensure. Not only do they have an opportunity to maintain their skills, they are remunerated at a reasonable level and at the same time, familiarize themselves with the healthcare system in Canada. At the same time, the healthcare system benefits by maximizing the skills of the providers

Employers report frustration that IMGs do not stay in their jobs for a long time before they enter residency positions. IMGs who are unsuccessful in attaining residency positions may be less skilled and require closer supervision.

CAPA also opposes the utilization of IMGs as PAs. They feel that physician assistants are a recognized profession with educational and practice standards. In fact, the current bylaws of CAPA permit only PAs who have completed educational programs in Canada or US to write the certification examination. At this point, no consideration has been given for challenge options for IMGs or other providers who may have the skill and experience to work successfully in a PA role. Clearly the creation of two tiers of PAs, that is certified versus non-certified, should be avoided.

Conclusion

The introduction of physician assistants may represent an excellent opportunity for governments to rectify some of the current medical manpower challenges faced by the healthcare system. Through the federal, provincial and territorial Advisory Committee on Health Delivery and Human Resources, governments could collaborative with employers and healthcare professionals to resolve policy issues, avoid inter-professional conflicts and reduce waiting times for patients.

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