Introducing physician assistants into new roles: international experiences

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The 35th Annual Physician Assistant Conference held in the United States in May 2007 provided an opportunity for Australia to learn from the experience of other countries

The 35th Annual Physician Assistant Conference of the American Academy of Physician Assistants (AAPA), held in Philadelphia in May 2007, was attended by almost 8000 delegates, including physician assistants (PAs), students, academics and policymakers. The conference aimed to promote professional development of PAs, develop ideas and provide education. It also featured an international forum focusing on global developments in PA-related activities. We report here on two countries that have recently introduced PAs, to identify opportunities for improving Australia's transition into implementing the PA role.

Physician assistants: a possible solution to workforce shortage in Australia

PAs are health care professionals licensed to practise medicine under physician supervision.[1,2] They were introduced in the United States in the 1960s to alleviate shortage and maldistribution of primary care physicians. The PA role has now spread outside the US, with various levels of development underway around the world (Box).[3-10] The role is now internationally recognised as part of a solution to the combined issues of health workforce shortage and increased demand for health care services.[11]

Several Australian groups, including public and private health providers in Queensland, the University of Queensland (Centre for Military and Veterans' Health and the Centre for 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]

The international forum at the AAPA conference provided an opportunity for Australian delegates to learn from the experience of other countries that have undertaken similar projects. Of eight forum presentations focusing on new and emerging roles and experiences, those from Canada (Ontario) and Scotland were related to projects in pilot phases and were considered the most relevant to the Australian situation.

The Ontario experience

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

A broad government initiative known as HealthForceOntario established a bold and aggressive plan to ensure the right number and mix of health care providers in communities across the province, and to establish new and expanded roles in areas of high need. Implementation of this plan included the following key steps:

- May 2006: Enabling legislation is enacted for the demonstration projects.
- June 2006: Consultation with all stakeholders, including employers, educators, regulators, health professionals (eg, medical, nursing and allied health staff at Ontario's hospitals) and other experts (eg, Canadian Forces, University of Manitoba, Canadian Association of Physician Assistants, 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 practise in Ontario.
- May 2007: Employment of PAs and NPs to work at the 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 PAs and NPs.

The rapidity of this initiative's progress 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-trained PAs participating in pilot projects; completion of a PA competencies document; and significant government investment in the PA initiative.

State of development of physican assistant (PA)-related activities around the world[3]

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 United States-trained PAs in the national health system	Canada,* England,* Scotland,* The Netherlands*
Hosting workforce development conferences in which PA profession is proposed	The Netherlands,* England,* Germany, South Africa, Taiwan, China, Ghana
Developing and establishing formal affiliation agreements with US 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. ◆

Two elements are considered key. First, the PA role was already in place in the Canadian military as well as in the health care system in the province of Manitoba.[7] This allowed policymakers 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.

The Steering Committee, co-chaired by two doctors and including a broad base of stakeholders (eg, PA experts and educators, and representatives from partner organisations, nursing, community clinics and academia), met monthly to facilitate communication. Six subcommittees and working groups were responsible for research and design of key components of the project, with a focus on: developing Ontario PA competencies; defining PA scope and role definition; determining compensation; establishing educational programs; addressing liability issues; establishing evaluation; launching demonstration projects in clinical settings; recruiting; and developing communications.

With its combination of professional expertise, the Steering Committee overcame a number of challenges such as recruiting the required number 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 projects that are 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 have expressed interest in employing a PA, although only 40 PAs are being recruited.

Until HealthForceOntario produces enough "home-grown" PAs, Ontario will recruit PAs with formal education from other jurisdictions, such as retired PAs from the Canadian Forces, and PAs from around Canada and the US who are eligible for Canadian PA certification.

The Scottish experience

At the 2006 AAPA conference in San Francisco, Scotland announced a demonstration project and 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 in Scotland to work on a 2-year contract. They are deployed in demonstration projects at various sites, in the areas of family medicine and emergency medicine.[10]

The leaders of the research team, Ricky Bhabutta (a British Army doctor, and Senior Medical Officer, Scottish National Health Service [NHS]) and Patricia O'Connor (National Clinical Coordinator PA Project, Scottish NHS), discussed the first 6 months of their demonstration project, which began in November 2006.

One of the main challenges they faced was the logistics required in settling the expatriates into Scottish life and culture. Despite this, the successful aspects of their project included:

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

The PAs working in Scotland also reflected on their experiences and suggested some things they felt could be done differently. They proposed that a site visit would have allowed them to obtain a better set of expectations regarding the relocation and demonstration process. They felt that a lack of clarity of the job description provided a source of confusion and frustration, and that the recruitment period was too short. The lack of definition of the supervisor role also created some initial confusion.

The supervisors and project managers added a few other aspects that 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 the PA is not a registered profession in the United Kingdom. Consequently, the PAs are working under a delegation and referral clause. Discussions about further 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 to start a university-based program in Edinburgh.

The assessment team reflected on a number of observations from the first half of the 2-year experience. A needs assessment by a workforce scholar was deemed a necessity, as it provided a solid literature review on various roles and experiences in the US and Canada.[10] For instance, it prevented the "name game" that England experienced (eg, "medical care practitioner" instead of "physician assistant"). Furthermore, drawing on American PA consultants, site visits, involving the citizenry of small towns, and attendance of conferences (eg, those of AAPA) were considered beneficial.

According to Dr Bhabutta, it is only a matter of time before PAs are dispersed throughout the North Atlantic Treaty Organization (NATO) countries.

Lessons learned

The experience of these two Commonwealth countries gives some indication of how implementing a PA-type role in Australia can be successfully achieved in a timely manner. The outcomes of this important conference showed that strategies likely to ensure success include reviewing the literature and incorporating the following essential elements:

- an active steering committee composed of a broad base of stakeholders;
- legal discussion around enabling legislation and the delegation role of doctors in supervising PAs;
- a recruitment process, conducted by a professional agency, that draws on these lessons; and
- clearly defined roles for both PAs and supervisors.

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Competing interests

None identified.

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