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JWU PA Class of 2020

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Introduction: Four Decades of PAs in Rhode Island

ROBERT B. HACKEY, PhD
GUEST EDITOR

As the Physician Assistant (PA) profession celebrated its 50th anniversary in 2017, the number of PAs authorized to practice in Rhode Island continued to grow rapidly. As of June 2018, the Rhode Island Department of Health reported that more than 550 PAs currently hold an active license to practice in RI. Notably, 111 (20%) of the state's PAs first obtained their license between January 1, 2017 and May 31, 2018.

Rhode Island is now home to two PA training programs. The state's first PA program, established at Johnson and Wales University (JWU) in 2012, graduated its first class of 23 students in 2016, and a second class of 24 students in 2017. Bryant University's program, established in 2014, graduated its first class of 29 students in March, 2017. Students from each program excelled on the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on the Certification of Physician Assistants; 100% of first-time takers from JWU passed the PANCE in both 2016 and 2017, and 97% of first-time test takers from Bryant graduates passed in 2017.¹ Both programs are highly selective, accepting roughly 5% of all applicants.

Early conversations about PAs in Rhode Island

Protecting the public, rather than expanding the supply of allied health providers, framed early deliberations about licensing PAs in Rhode Island. Following the lead of the American Medical Association (AMA), the Rhode Island Medical Society (RIMS) supported the general notion of PAs practicing under physician supervision. In 1970, John Farrell, the executive secretary of RIMS, presented a report to the RIMS House of Delegates on the AMA Congress on Health Manpower held in October 1970.² The AMA report encouraged states to amend existing medical practice acts "to broaden the authorization for delegation of functions" to physician's assistants, nurse midwives, nurse practitioners, and other non-physician providers. The report recommended that "a proviso should be included that the delegate is authorized to perform under appropriate supervision functions warranted by his education, demonstrated ability, and training... State medical associations are encouraged to support such amendments."² By embracing the AMA's recommendations, Rhode Island adopted a wait-and-see approach to PA licensure, in contrast to North Carolina, where physicians and policymakers collaborated to draft model legislation to regulate PAs in 1970.³ The Allied Health Professions and

Services Committee recommended "that the House of Delegates request a moratorium on licensure of any additional health occupations in Rhode Island until such long-range solutions are developed." The committee's recommendation, however, did not "preclude amendment of existing licensure laws to permit expanded functions."⁴

In the absence of a regulatory framework, no physician assistants practiced in Rhode Island in the early 1970s. By early 1972, the Medical Society's Allied Medical Professions and Services Committee reported that it had received local inquiries "concerning the licensing of a Physician Assistant."⁴ Although Committee members discussed PA programs and scope of practice, RIMS did not press for legislation to license PAs in Rhode Island. Interest in licensing PAs in Rhode Island continued to grow among PAs during the early 1970s. By 1975, Dr. George Meissner reported that the Allied Health Professions and Services Committee received inquiries from recent PA graduates interested in practicing in the state.⁵

The evolution of PA legislation and regulation in RI

Physician Assistant practice in Rhode Island was authorized by the General Assembly with the passage of S-2384, "An Act to Facilitate an Increase in Medical Manpower Through the Use of Physician Assistants" on June 4, 1976. This bill – Chapter 274 of the Public Laws of 1976 – defined the criteria for licensing and regulating PAs in Rhode Island. The new law established "a framework for the development of a new category of health manpower to be known as the physician assistant" and defined the scope of PA practice. S-2384 sought to "encourage the more effective utilization of the skills of physicians by enabling them to delegate health-care tasks to qualified physician assistants where such delegation is consistent with the patient's health and welfare." The new law took effect on January 1, 1977. The Medical Society first accepted PAs as affiliate members in 1978. Although the legislation paved the way "for innovative development of programs for the education of physician assistants," it would be four decades before the first class of PAs graduated from a training program based in Rhode Island.

Physicians in Rhode Island – and the Medical Society in particular – engaged in a lively and spirited debate about the autonomy and supervision of PAs during the 1980s. In 1982, the General Assembly took up the issue of updating

the licensing framework established in 1976 with a new legislative proposal – H82-7695 – that authorized PAs to provide “patient services” broadly defined. The bill immediately sparked controversy within RIMS, which included PAs as members. Since the passage of Rhode Island’s initial PA licensure bill, the concerns about a shortage of physicians in the 1970s had dissipated. In the wake of a sobering report by the Graduate Medical Education National Advisory Committee in 1981, projections of a physician shortage were replaced by growing concerns about an oversupply of doctors. At the Jan. 20, 1982 meeting of the Medical Society’s House of Delegates, Dr. Albert Tetreault presented a resolution that declared:

“Whereas there is no shortage of Physicians in the State of Rhode Island; Whereas the level of clinical medicine rendered by physicians to their patients is always superior to any diagnosis and prescribed treatments delegated to or performed by non-physicians. Be it resolved that the practice of Medicine in Rhode Island by non-physicians outside of the hospital setting is not in the best interest of patients and should not be justified except under life-threatening circumstances. Be it further resolved that the Rhode Island Medical Society urgently pursue all legal channels to immediately curtail existing practices and those extensions of privileges conferred on licensed non-physicians that sanction future abuses.”⁶

After a lively debate at the March 24, 1982 RIMS meeting, the assembled delegates rejected the resolution to oppose the bill by a margin of 24-19.⁷ Several physicians present expressed their opinion that “PAs are well-trained and are assets to the health-care delivery team” and that “PAs, as members of the Society, deserve its support.”⁷ Furthermore, physicians also noted “PAs have attempted to work with the Society, while other paraprofessionals seeking legislation have not done so.”⁷ Thus, RIMS suggested that with appropriate revisions, it could support the bill. Delegates charged Dr. Walter Cotter with the task of preparing revisions for legislators to consider before voting on a final version of the bill. In a letter to the House of Representatives, Dr. Cotter noted that the original legislation was “unclear and might leave the physician assistant exposed to a hazard of less than our best medical care.” In particular, the House of Delegates recommended that “it is better to delete the words patient services and substitute the following: Those certain services in which he is trained.”⁸ By carefully circumscribing PAs scope of practice, the amendment recognized the generalist nature of PA education. As Dr. Cotter noted, the suggested amendment protected the “patient, the supervising physician, and the physician assistant” for the PA could not be “assigned tasks for which he is not trained or given responsibilities outside of his field of expertise.”⁸ The May 1982 newsletter of RIMS noted that, “in a special session of the Rhode Island Medical Society House of Delegates held May 3, 1982, a motion was unanimously voted that the

Society go on record as supporting a bill in the Rhode Island General Assembly, H82-7695-A, ‘An Act Relating to Physician Assistants.’”⁷

The success of the Medical Society in amending the content of the PA legislation in 1982 underscored the political influence of physicians over health policy issues at the General Assembly and reinforced the primacy of physicians in the PA-physician relationship. As Drs. Mario Tami and Albert Tetreault observed in the June 1982 RIMS newsletter, physician lobbying “made certain that the composition of the physician assistant legislation which was signed into law was acceptable to the Rhode Island Medical Society House of Delegates.” As RIMS President Dr. Charles Shoemaker noted in 1984, “during the past ten years, the Rhode Island Medical Society has devoted considerable time and energy to blocking efforts by non-physician health providers to expand their professional roles and privileges...Previous years have seen testimony from the Society against chiropractors, physician assistants, and other groups who attempted to extend their practice privileges by legislative fiat. The primary focus of our concern has been to protect patients by requiring adequate training and experience for all providers of medical care. Yet each year, we find ourselves cast in the role of the establishment fighting the underdog and being accused of protecting our own financial interests.”⁹

By the early 1990s, however, the scope of PA practice expanded to include writing prescriptions and medical orders.¹⁰ The statutory framework governing PA practice can be found in Chapter 5-54 of the Rhode Island General Laws (2012). Under Section 5-54-4, “a physician assistant may perform medical services when such services are rendered under the supervision of a registered physician. Such supervision shall be continuous but need not be in the personal presence of the supervising physician or physicians.” The Rhode Island Department of Health is responsible for developing rules and regulations to govern the licensure, scope of practice, supervision, and professional conduct of PAs, as outlined in the Department’s Rules and Regulations (216-RICR-40-05-24).

Where do PAs practice?

Although the architects of the PA profession originally envisioned it as a way to address the shortage of primary care providers, the proportion of PAs choosing careers in primary care continues to decline over time.¹¹ This trend is even more pronounced in Rhode Island, as fewer than one in five PAs (18.8%) pursued primary care as their area of practice in 2015; nationally, 28.5% of PAs worked in primary care settings.¹² While some PAs described primary care as “part of the profession’s DNA,” a majority of PAs have pursued specialty careers since the late 1990s as “robust nonprimary care career opportunities draw the majority of new PA trainees.”¹³ This trend, however, reflects the availability of job openings. More than 2/3 of job postings for PAs in 2014 were

in medical specialties; only 19% of available positions were in primary care.¹⁴ Unlike nurse practitioners, who can practice independently in 20 states, the role and scope of practice of PAs are defined by supervising physicians.¹⁵ Today, fewer physicians opt for careers in primary care, as more recent graduates opt for careers in surgical or medical specialties over time.¹⁶ Thus, it naturally follows that fewer opportunities will exist for PAs to pursue careers in primary care settings. In addition, both salary considerations and working conditions also shape the appeal of specialty careers versus primary care practice for new PA graduates. PAs practicing in primary care settings saw an average of 73 patients per week, compared to 63 patients per week for non-primary care PAs.¹⁷ In addition, the mean base salary of primary care PAs was \$91,309 in 2014, compared to \$99,608 for PAs practicing in other settings.¹⁷ A 9% salary differential, coupled with a higher patient load, does little to improve the appeal of primary care for recent graduates.

The growing utilization of PAs in Rhode Island in surgical and medical specialties reflects the flexibility of PA education and training. As Reamer Bushardt and Ruth Ballweg observed, “a generalist education with clinical and interpersonal skills that translate across myriad practice settings has powered PA adaptability.”¹⁸ PAs acquire new skills over time as they gain experience through supervised practice and their practice setting and specialization can evolve over time. This adaptive and evolutionary quality of PA education limits the appeal of formal credentialing or specialty certification of PAs. As the president of the American Academy of Physician Assistants argued in 2006, “We will do everything we can to defend the flexibility of this profession – to move from specialty to specialty while at the same time protecting the patient.”¹⁵

References

1. PANCE results for Bryant University are available at <https://gradschool.bryant.edu/resources/PANCE%20Five%20Year%20First%20Time%20Taker%20Summary%20Report.pdf>; Johnson and Wales University PANCE results are available at <https://www.jwu.edu/academics/colleges/college-of-health-and-wellness/physician-assistant-studies/graduate-performance-on-certification-exam.html>. Accessed June 7, 2018.
2. Farrell JE. AMA Congress on health manpower. Proceedings of the Rhode Island Medical Society House of Delegates. March 8, 1972.
3. Estes EH, Carter RD. Accommodating a new medical profession: The history of physician assistant regulatory legislation in North Carolina. *NC Med J*. 2000; 66(2): 103-107.
4. Meissner G. Allied medical professions and services committee. Report to the Rhode Island Medical Society House of Delegates. January 19, 1972.
5. Meissner G. Allied health professions and services committee. Report to the Rhode Island Medical Society House of Delegates. January 29, 1975.
6. Proceedings of the Rhode Island Medical Society House of Delegates, January 20, 1982.
7. Proceedings of the Rhode Island Medical Society House of Delegates, May 3, 1982.
8. Letter from Walter Cotter, MD, to the Rhode Island House of Representatives, May 4, 1982. *RIMS Newsletter*. May 1982. *RI Med J* 65 (5): 173.
9. Shoemaker C. Non-physician health providers: A more systematic approach is needed. *RI Med J* 1984;67(4): 161.
10. Chapter 72, Public Laws of 1991 (91-S-915 am Approved June 11, 1991).
11. Morgan PA, Hooker RS. Choice of specialties among Physician Assistants in the United States. *Health Aff*. 2010; 29 (5): 887-92.
12. National Commission on Certification of Physician Assistants. 2015 Statistical Profile of Certified Physician Assistants. Accessed May 11, 2018, from www.nccpa.net/research.
13. Brock DM. Will primary care be the PA profession's future? *JAAPA* 2017; 30 (9): 7-8.
14. Morgan P, Leach B, Himmerick K, Everett C. Job openings for PAs by specialty. *JAAPA* 2018; 31 (1): 45-47.
15. Jones PE. Physician assistant education in the United States. *Acad Med*. 2007; 82(9): 882-87.
16. Hackey RB, Grasso V, LaRochelle M, Seaver K. Rethinking the shortage of primary care physicians. *JAAPA* 2018; 31 (6): 47-50.
17. Coplan B, Smith N, Cawley JF. PAs in primary care: Current status and workforce implications. *JAAPA* 2017; 30 (9): 35-42.
18. Bushardt RL, Ballweg R. Reflecting on the PA profession's 50th anniversary. *JAAPA* 2017; 30 (10): 9-10.

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Creating Rhode Island's First PA Program

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Rhode Island's first physician assistant (PA) program at Johnson & Wales University graduated its inaugural class of physician assistant students on May 21, 2016. These twenty-three students and students in the Class of 2017 (all of whom in both classes passed the Physician Assistant National Certification Examination on their first try) raised the profile of the physician assistant profession in the State of Rhode Island. Over half of these new PAs took positions in Rhode Island. The following describes how the vision of Johnson & Wales University became a reality.

Johnson & Wales University (JWU) was founded in 1914 in Providence, Rhode Island. Today the Providence Campus is the largest of the four Johnson & Wales University campuses, with more than 8,500 students from all 50 states and more than 60 countries. The university's mission statement defines its purpose – *Johnson & Wales University...an exceptional education that inspires professional success and lifelong personal and intellectual growth*. All of JWU's degree programs embrace a professional and practice-based model of student learning. The idea of offering an M.S. in Physician Assistant Studies reflected the university's history and mission.

JWU has deep experience in delivering professional programs, including degree programs focused on health and wellness in culinary nutrition, dietetics, and applied nutrition. The success of these programs led administrators to explore other potential programs in the health professions. In 2009, JWU leadership began to explore such programming in the health care area and for the reasons discussed below, attention on physician assistant studies quickly became a focus. JWU then engaged the services of an experienced consultant in PA education to consider facility, faculty, clinical training needs, and to become familiar with the Accreditation Review Commission for Physician Assistant Education (ARC-PA) standards and processes (<http://www.arc-pa.org/>).²

Existing physician assistant programs in New England were located in the Greater Boston area, Connecticut, or Maine. At the time, Rhode Island was one of only two states in the United States without a PA program. Administrators believed the program would have market viability. The concentration of health care providers in Southern New England, and Rhode Island in particular, provided ample clinical training sites for JWU students. This perception was confirmed during preliminary clinical site development

work. A Physician Assistant Advisory Committee visited local hospital systems to explore interest in supporting the program and the potential availability of clinical training in the area. In addition, university officials held meetings with the Hospital Association of Rhode Island, the group that coordinates clinical sites for the state's nursing programs, to explore clinical training possibilities.

Creating a PA program in Rhode Island had the additional benefit of reducing the financial burden of PA education for Rhode Islanders and encouraging program graduates to stay in the area to practice. If students could continue to live at home with parents or their families, the stability of their living situation and resulting savings could reduce their debt burden, thus allowing graduates to potentially choose a practice area in primary care that is traditionally a lower paying opportunity. Demand for additional licensed physician assistants was – and remains – strong. The U.S. Bureau of Labor Statistics (BLS) data at the time showed an estimated 30% increase in need through 2020. Current BLS data projects that PA employment is projected to grow 37% from 2016 to 2026.¹ A market research study completed for JWU by the Educational Advisory Board (EAB), a well-known higher education research organization, also projected that demand for PAs in Southern New England would increase by 8.8 percent from 2010 to 2012. At the time, there was (and still is) an acute need for primary care practitioners in Rhode Island.

The Provost's Council and the University Dean's Committee both enthusiastically supported the development of a high-quality program in this area in 2010. The notification of intent to apply for Accreditation-Provisional was completed and approved by the University Provost and President. Subsequently, an application for Accreditation-Provisional was submitted and the ARC-PA set the date of June 6-7, 2013 for the site visit. A seven-year financial model was developed for the program by the Assistant to the Provost. In October 2012, JWU purchased a two-story, 18,000 square-foot brick building at 157 Clifford Street as the future home of the program. I was hired to lead the program through the process of curriculum design and the three-step accreditation process, as well as to manage its full launch and ongoing operations. As a native Newporter and URI graduate, I had a long-standing interest in developing a PA program in Rhode Island. PAs from the RI Academy of Physician Assistants

and the Rhode Island Medical Society – of which all RI PAs are also members – wholeheartedly supported the initiative and proved instrumental in galvanizing support from the healthcare community. Meetings occurred with leaders from every Rhode Island hospital group, large group practice, and community health center; with insurance and pharmaceutical industry representatives; with the RI Department of Health and Board of Licensure; with RI congressional representatives; and with representatives from every college and university in RI.

JWU developed articulation agreements with Providence College (PC) and the University of Rhode Island (URI) that guarantee an interview if the student meets specific undergraduate course and experiential (direct patient care) hours. These requirements are above the minimum course and GPA requirements which allow a student to qualify for consideration through our usual process. We worked with URI and PC pre-professional health advisors to develop these requirements; knowing the rigor of the courses URI and PC students take gives us confidence that they will succeed in our program.

New models of health care delivery, such as the patient-centered medical home, call for a team-based approach from providers, so it makes sense that the education of those professionals include elements of that teamwork. To advance that principle, on March 27, 2013, JWU's Center for Physician Assistant Studies and Brown University's Alpert Medical School signed a memorandum of understanding to explore possible collaborations. The leadership of the Alpert Medical School recognized the impact that physician assistants have as part of the interprofessional health care team. "The new model of health care is patient-focused, IT-driven, and team-based," said Dr. Edward Wing, then-dean of medicine and biological sciences at Brown. "Alpert Medical School is fortunate to partner with JWU to explore interdisciplinary training opportunities with its physician assistant program. This new collaboration makes good sense as we work toward expanding the entire health care workforce."³ Construction work on the building began in fall 2012; the new Center for Physician Assistant Studies was completed in early 2014.

The mission of the Physician Assistant Studies program at JWU is to educate students to become collaborative practitioners with the respect, empathy and trust inherent to patient-centered, humanistic health care. This statement emphasized the team-based, interprofessional, patient-centered approach so vital to high quality healthcare. The JWU PA program forged a relationship with the Arnold P. Gold Foundation to bring their experience in the humanistic aspects of patient care to our program. The mission statement informs everything about the program, from the architectural design of the Center that intentionally emphasizes community, to the structure of the curriculum that de-emphasizes competition and emphasizes patient-centeredness

and provider self-care, to the recruitment of faculty and staff and the qualities of students we accept into the program. During the development of the program, the curriculum designers used the Physician Assistant Competencies developed by the American Academy of Physician Assistants.⁴ In addition to the ARC-PA Standards, JWU also employed the Physician Assistant National Certification Examination (PANCE) blueprint, and prior experience to determine the necessary depth and breadth of the curriculum.⁵

The JWU PA curriculum is a comprehensive course of study designed to prepare students for entry into clinical practice. The didactic portion consists of 51 weeks (60.5 credit hours) of rigorous instruction and study in all areas of medicine as a means to prepare students for the 49 weeks and 43.5 credits of clinical training they will receive during the second year of the program. This is consistent with the national average of 52.7 weeks and 63.8 credit hours for the didactic phase and 51.1 weeks and 44.5 credit hours for the clinical phase.⁶ Students apply through a centralized application service. Minimum requirements include a completed undergraduate degree with a minimum undergrad cumulative GPA and BCP (biology, chemistry, physics) GPA of 3.0. Required courses are in anatomy, physiology, biology, chemistry (all with labs), English, math, and the behavioral sciences. Students must have a minimum of 250 hours of direct patient care as well as experience in shadowing a PA. GREs are required. Since the start of the program, students chosen for interviews have GPAs and patient care hours significantly above the minimums.

Physician assistant programs are based on a medical model and all new and developing programs are required to award a master's level degree. The Summer semester of the didactic phase provides basic science foundation for the Fall and Spring modules. Summer courses are coordinated such that when a body system is being taught in the anatomy lecture and cadaver lab (Applied Anatomy), the same system is being taught in the history and physical examination course (Patient Care). Basic modules are also taught in microbiology, immunology, cell physiology, genetics, and pharmacology.

The following semesters contain the clinical preparatory sciences courses in Clinical Medicine, Pharmacotherapeutics, Diagnostics Skills, and Patient Care. These courses run longitudinally in the Fall and Spring but are presented in module format, starting with the clinical medicine, pharmacotherapeutics, diagnostic skills, and patient care associated with the HEENT system and progressing through cardiology, pulmonology, and so on. Students are immersed in a body system for one, two, three, or more weeks, tested on the content and move on to the next module. Toward the end of the didactic year, students revisit each system in the context of a specific population in their women's medicine, pediatric, geriatric, general surgery, and emergency medicine modules. Topics in behavioral medicine, public health to

emphasize the social determinants of health, evidence-based research, ethics, and professional practice are included in a year-long course on Professional and Health Policy Issues. Approximately sixty percent of the lecturing is done by PA faculty, all of whom are certified and continue to work clinically. The balance is taught by adjunct faculty, largely from the RI medical community and many of whom are also Brown affiliates.

JWU's rich history in the areas of nutrition and the culinary arts provides students with a unique "Cooking for Health & Wellness" course as part of the didactic year curriculum. Students are taught everything from knife skills to the choice of ingredients, to the hands-on preparation of healthy meals in the kitchens of our Cuisinart Center for the Culinary Arts. This course is also coordinated with their module: during the endocrine module, for example, students learn about food substitutions and preparation of meals for the diabetic patient.

The clinical year begins with Introduction to Clinical Practice that provides students with hands-on experience in skills that include splinting and casting, suturing, immunizations, venipuncture, and instruction at the Lifespan Simulation Laboratory. The clinical year consists of nine five-week rotations across all primary care disciplines (family medicine, internal medicine, and pediatrics), in addition to surgery, emergency medicine, behavioral medicine and women's health. This provides students with direct experience in varied disciplines of medicine, in a variety of settings to include inpatient, outpatient, emergency department and surgical environments, as well as opportunities to interact with patients across the life span in acute, emergency, chronic and preventative encounters. In addition, each student is required to complete a master's paper and presentation that combines scholarly activity with clinical practice by encouraging students to use evidence-based medicine to investigate a clinical question. Students have hands-on experiences in the above-listed settings. They work with MDs, PAs, NPs, and others on the team and under the supervision of the preceptor perform patient evaluation/diagnosis, develop treatment plans, counsel patients, etc. In the clinical year, following each clinical rotation students take a specific standardized examination developed by the national PA Education Association for each area...family practice, internal medicine, emergency medicine, etc. Preceptors also complete an evaluation for each student. Prior to graduation, each student completes a Master's Project which includes an objective structured clinical examination (OSCE) using the standardized patient program at Brown, takes a summative examination, and prepares a presentation based on a clinical question and using evidence-based medicine principles learned during the program. Graduation from an accredited program qualifies them to sit for the PA National Certification Examination developed by the National Commission for the Certification of PAs. Thereafter to maintain

certification, all PAs must accrue 100 hours of CME every 2 years and take a re-certification examination every ten years.

From the start, the Rhode Island Academy of Physician Assistants (RIAPA) and the Rhode Island Medical Society (RIMS) leaders and membership were overwhelmingly supportive advocates; representatives participated in ARC-PA site visits, served as lecturers and clinical preceptors, and participated as members of our Admissions Committee. Clinical preceptors and employers of our graduates tell us they like our students because they are "smart and kind." Today, over half of the students who have graduated from our program currently practice in Rhode Island.

References

1. Bureau of Labor Statistics, U.S. Department of Labor. Occupational Outlook Handbook, Physician Assistants. Accessed at: <https://www.bls.gov/ooh/healthcare/physician-assistants.htm>.
2. Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). Standards of Accreditation. 2018. Accessed at: <http://www.arc-pa.org/accreditation/standards-of-accreditation/>.
3. Medical School, PA Program at JWU Seek to Collaborate. *RI Med J*. 2013; 96 (4): 52. Accessed at: <http://www.rimed.org/ri-medicaljournal/2013/04/2013-04-52-news-complete.pdf>.
4. American Academy of PAs. Competencies for the Physician Assistant Profession. Accessed at: <https://www.aapa.org/career-central/employer-tools/employing-a-pa/competencies-physician-assistant-profession/>.
5. National Commission on Certification of Physician Assistants. Content Blueprint for PANCE. Accessed at: <https://www.nccpa.net/pance-content-blueprint>.
6. Scott C, Bouchard G, Brock D, Davison M, Dehn R, Hegmann T, Link M, Morgan P, Niebuhr B. Rebirth of the Curriculum Survey Report. Accessed at: <http://paeonline.org/wp-content/uploads/2016/10/Curriculum-Survey-2010.pdf>.

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Becoming a PA: Reflections from Johnson & Wales University Students

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INTRODUCTION

This collaborative student-authored piece features the perspectives of four different students in both the didactic and clinical years of the Johnson & Wales University (JWU) PA program. These student vignettes present a snapshot of life as a PA student. Ariana Africo grew up in North Providence and earned her B.S. in Biology from the University of New England. She is a first-year student in the PA program. Matthew J. DaCosta is a second-year PA student and a National Health Service Corps scholar. Originally from New Bedford, MA, he gained experience in mental health and emergency medicine before PA school; he holds a B.A. in Psychology from the University of Massachusetts-Dartmouth. Kayla Denis is a second-year student who spent much of her childhood as a competitive gymnast. Born and raised in Swansea, MA, Kayla graduated from Northeastern University, and worked as a medical assistant in her hometown for five years, where she developed a passion for medicine and patient care. Alysse Pazienza, a first-year PA student, is a native Rhode Islander who graduated from the University of Maryland with a B.S. in Kinesiology.

FIRST YEAR: ENDLESS POSSIBILITIES

ARIANA AFRICO, BS

To me, becoming a Physician Assistant is more than just getting to wear the white coat at the end of my program. It is about improving the gap in access and quality of healthcare for all. Physician Assistants are trained to provide high quality care to patients. We are able to perform a comprehensive history and physical, order and interpret lab tests and imaging, and prescribe medication. I take pride in our curriculum at Johnson & Wales University where we are taught to not only be well-versed and empathetic providers, but also how to take a humanistic approach to medicine. This is looking at our patients as more than just their ailments. It is treating the whole patient, not just the disease itself. It is about forming good relationships between the patient and provider as well as being sensitive to the values and beliefs of our patients to overall improve their care.

Being a PA is about taking a team-based approach to improve patient care. We must collaborate with our supervising physician and communicate well with our colleagues. While doing so, we must not forget to recognize that all health professionals play important roles on our healthcare team. This team-based approach optimizes patient care and improves outcomes.

PA school helped me find where my passion lies in the medical field. At the start of PA school I had my heart set on becoming a surgical Physician Assistant. During my second year, however, other specialties such as endocrinology and pediatrics also piqued my interest. At JWU, our clinical rotations can help solidify where our passion really lies by exposing us to several specialty areas.

We must never forget that medicine is a realm of endless possibilities. With so many intriguing specialties in the medical field, at some point in my career I want to be able to switch to a new specialty to further my knowledge and training. The beautiful thing about the Physician Assistant profession is that it is extremely versatile and will allow me to make the switch to a new specialty without additional schooling. Instead, we train extensively on the job to become proficient in the field. This aspect of the Physician Assistant profession is what made it stand out from other health professions to me. If doctors desire to switch specialties, they would have to get additional training through a fellowship or residency. Even if nurse practitioners desired to switch to a specialty that did not fall into the scope of their education, they, too, would have to supplement their education through additional schooling. Becoming a Physician Assistant not only gives me the ability to choose, but also the ability to change and grow. When I finally get to wear that white coat, I will wear it with pride because it will mean more to me than just the conclusion of my program. It will symbolize my career and passion coming together while I make a difference in the lives of my patients.

FIRST YEAR: COLLABORATION AND VERSATILITY

ALYSSE PAZIENZA, BS

"What do you want to be when you grow up?" was the million-dollar question when I was in high school. It wasn't until I started college that I felt a compelling urgency to make a decision about what I wanted to do; yet, at that point in my life, I had no specific career aspirations. I just knew that I had an interest in science and helping people. It wasn't until my freshman year of college that I heard the job title "Physician Assistant (PA)." I did a quick Google search and found that PAs have the ability to see, diagnose and treat patients under a doctor's supervision. PA school would only require an additional 2-3 years of education following my undergraduate degree, and I would have the ability to switch specialties throughout my career. This lateral mobility and the flexible schedule that I would have as a PA seemed to fit

my goal of one day starting a family while maintaining my career. As I looked further, I found that PAs have a fundamental focus on the patient care aspect of medicine. I would be able to spend quality time getting to know my patients while effectively taking care of their medical needs.

“Let’s start an IV... Get the family on the phone... Hold compressions and check the rhythm.” I was now standing in a trauma bay at Rhode Island Hospital, watching as the trauma team worked diligently to save a patient’s life. Amongst the chaos, I felt a sense of admiration. It was evident that the patient was the central focus of the team’s work. While the attending physician called out instructions, the PA completed the exam and helped manage the patient’s airway while the nursing staff continued compressions and administered medications. This shadowing experience solidified my decision to become a PA. Whether in a trauma bay resuscitating a patient or in a primary care office creating a care plan, I would have the opportunity to be an integral part of a team and impact many lives.

During my shadowing experiences, I observed PAs perform an array of duties from reassuring patients and their families, to completing lumbar punctures, assisting with cardiac catheterizations and surgery. I realized that a PA’s abilities are far-reaching and encompass endless possibilities to be both autonomous providers and essential team members.

The PA profession encompasses everything I am already passionate about: medicine, humanism, and versatility. I am truly humbled to have the opportunity to be whatever my patients need during times of vulnerability. Whether adjusting a patient’s medications to enhance comfort, reviewing labs and imaging to confirm a diagnosis, or holding their hand while giving difficult news, I feel honored to join this profession. All of these values are also so intricately woven into the Johnson & Wales PA program, which made it an easy decision for me to pursue my education there. Each day, I am reminded of how important my role as a PA will be, not only as a member of the healthcare team, but as a human being who cares deeply for others.

SECOND YEAR: WE ARE HUMBLLED

MATTHEW J. DACOSTA, BA

The transition into the clinical phase of PA training mimics a grayscale. The black and white hues of didactic medicine transform into real-patient scenarios, often muddled with gray areas. Amidst the novelty, we are humbled.

The challenges of clinical practice require a new mode of critical thinking. Independent of science and medicine, the human element can exhibit an unfamiliar variability. As echoed by our faculty, there is certainly great wisdom in the phrase “diseases don’t always read the book.”

Fortunately, all PA students possess a foundation of knowledge that improves with each encounter. Through independent study, preceptor guidance, and carefully listening to our patients, we begin to find some clarity.

During our journey of lifelong learning, we continue to derive lessons from the gray areas of medicine. Its ubiquity partially motivates clinical excellence. Regardless of what lies on the grayscale of our training, we truly find solace in the one aspect that underlies it all: the sacred relationships we share with our patients.

SECOND YEAR: DRINKING WATER FROM A FIRE HOSE

KAYLA DENIS, BS

There are many paths to choosing a career in medicine. I was drawn to the PA profession for many reasons, but particularly for the collaborative nature of PA practice. I thrive in team-based environments where the ideas and actions of many are stronger than that of one. This especially spoke to me given the evolution of modern medicine, where the idea of collaborative care via an inter-professional team of providers is of utmost importance. I was also intrigued by the fluidity in choosing a specialty and the option to change specialties without additional training. With my background as a competitive gymnast, I’ve always had a passion for orthopedics, but I loved the notion that I was not limited to a choice I made fairly early in my professional journey. Lastly, and most important for me, was the patient-centered and humanistic care that resides at the center of the PA profession.

Life as a PA student is difficult. There is just no other way to put it. My favorite analogy comes from one of my professors, who said, “PA school is like drinking water from a fire hose.” The amount of information presented in such a short period of time is intimidating and overwhelming, and despite all of our best efforts, some of it will pass by unabsorbed. But that is a key element of the medical profession in general. There really is no way to know everything about every disease or diagnosis. This is not only humbling but truly is the beauty of medicine. It takes a team of passionate, dedicated individuals to provide the type of care we all hope to provide. I think the same can be said about the path through PA school, where your friends and family are the essential support system helping to hold you up when the task ahead is daunting. I am forever thankful for the countless loads of laundry, grocery store trips, ready-to-bake meals, and family game nights that left me with one less item on my to-do list during late nights reading ECGs, and which also provided the mental decompression essential for success.

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PAs: From Training to Practice

ASHLEY A. HUGHES, MSPAS, PA-C

In 2014, Johnson & Wales University (JWU) enrolled its inaugural class of Physician Assistant (PA) students, making it the first Physician Assistant Program in the state of Rhode Island (RI). The program is now enrolling its fifth class under the direction of George Bottomley, DVM, PA-C. Since its inception, this Master's degree program led and taught by certified PAs and local physicians, has addressed a shortage of health care practitioners in RI.

The program's didactic phase begins in the summer, where four courses run simultaneously. Courses in anatomy, patient care, foundations of medicine and professional health and policy launch the students' education. In the first week, students are introduced to the 24-hour access cadaver lab, assigned cadavers and are provided with dissection protocols. They then begin a year-long journey with them. Students are guided through detailed sequential dissections to identify clinically relevant gross, regional and surface anatomy by our Anatomist, Patricia Brady, who holds a PhD in biomedical sciences. Anatomy sequencing is coordinated with patient care courses. This harmonized learning aids students in integrating information between courses and in the practical application of anatomical knowledge for understanding of physical examination findings.

The cadaver lab is woven into the curriculum as an additional tool to supplement the understanding of medicine. For example, within the cardiology module, students return to the lab to identify cardiac pathology. As Faculty Assistant Professor Victoria Miller, MSPAS, PA-C, observed, "In the summer, the students begin the course with the eyes of an anatomist and return to the lab with the eyes of a pathologist." Second-year students devote time in the lab to practicing procedural skills before entering the clinical year.

At the culmination of the academic year, students hold a closure ceremony where they gather with faculty to express their thanks for the year-long relationship and lasting gift of medical knowledge gained from their cadavers and the education the experience imparts. This event highlights the JWU Program mission of developing humanistic, respectful and empathetic PAs who will carry these values forward with them in their future careers.

The remainder of the students' didactic education is designed for synergistic learning by presenting course material in a module specific format. The fall and spring semesters run for 16 weeks and each semester contains module

information delivered over 1 to 4 weeks' time. The length of each module varies based on the National Commission on the Certification of Physician Assistants (NCCPA) content blueprint organ areas to ensure adequate coverage of material by the completion of the didactic year to best prepare students for both clinical rotations and the Physician Assistant National Certifying Examination (PANCE). Modules consist of Dermatology, HEENT, Hematology, Cardiology, Pulmonology, Musculoskeletal, Renal, Urology, Neurology, Endocrinology, Infectious Diseases, Gynecology, Obstetrics, Gastroenterology, Surgery, Pediatrics, Geriatrics and Emergency Medicine. Each module contains clinical medicine lectures along with associated diagnostic skills, patient care, pharmacology lectures and problem-based learning cases, where students apply what they have learned in the module to clinical scenarios. This method of delivering medical education, allows students to learn, synthesize, and apply their knowledge in real time.

To better emphasize lifestyle changes as a way to manage disease, Assistant Professor Mallory Sullivan, MSPAS, PA-C, coordinates the highly regarded "Food as Medicine" course. Students collaborate with PA faculty and JWU chefs in the industrial kitchens where they learn how to use food as medicine. This trailblazing course links clinical medicine with patient care and nutrition. Students work to design and implement meal plans for a specified set of health conditions. They learn how proper nutrition can prevent illness as well as how to tailor nutritional education delivered to patients based on health problems, dietary restrictions and cultural needs. "Food as medicine" is designed to arm the PA with the tools to empower patients with the knowledge necessary to maintain their own nutritional wellness and this course achieves that objective.

PA education at JWU aims to develop generalist health care practitioners capable of working in dynamic, team-based environments. By introducing team-based care early in education with interprofessional events, students have opportunities to collaborate with other health care professionals to augment their understanding of the role of other professions in health care delivery. The students also learn leadership skills, communication skills, and strategies to create patient-centered clinical care plans. JWU PA students work alongside Respiratory Therapy, Occupational Therapy, Physical Therapy and Nursing students in patient encounters

with community volunteer patients and simulation lab exercises. Assistant Professor Rebecca Simon, MS, who holds a master's degree in Occupational Therapy, coordinates interprofessional events. These experiences optimize the understanding of each specialty's role in patient care and facilitates collaboration between all parties for benefit of comprehensive and fluid patient care.

The second year of the JWU PA program curriculum is managed by Assistant Professor Kelli Kruzel, MSPAS, PA-C, who works diligently to place students in nine, five-week clinical rotations that provide the students an opportunity to practice skills they have learned. Core rotations in family medicine, internal medicine, pediatric medicine, women's health, behavioral and mental health, surgery, emergency medicine and two elective rotations, afford students a well-rounded clinical experience that prepares them for entry-level clinical work.

Physician assistants are educated in the medical model and typically begin their clinical careers upon graduation. PAs work in association with a supervising physician. The relationship between PA and supervising physician is one of joint practice. PAs can examine, diagnose and treat patients independently provided that the care delivered falls within the scope of practice of both PA and supervising physician. The role of the supervising physician is to provide professional guidance and support to the PA on medical care plans on a case-by-case basis. This relationship requires mutual respect and trust and places the patient at the center of medical care. Each state has its own regulations regarding the level of supervision a PA requires to practice medicine. The Rhode Island Department of Health Rules and Regulations for the Licensure of Physician Assistants states, "The constant physical presence of the supervising physician or physician designee is not required. It is the responsibility of the supervising physician and physician assistant to assure an appropriate level of supervision depending on the services being rendered."¹ RI state law further states, "The supervising physician or physician designee must be available for easy communication and referral at all times."² Each pairing of supervising physician and PA should have a written supervisory agreement clearly outlining this agreement. There is flexibility in the supervisory relationship based on the experience of both supervising physician and PA and office or hospital medical staff laws.

What makes the PA profession unique is the ability of practicing PAs to transition from one field of medicine to another when the desire to make a change presents itself. While this can be challenging and requires additional self-paced and employer required learning, it is entirely possible for the generalist-trained PA. PAs train and receive their board certification in general medicine, rather than in the care of a defined patient population, which provides a broad and solid foundation of medicine applicable to the care of patients in different clinical settings. Additionally,

post-graduate training programs exist and serve the purpose of providing in-depth training to new graduates or PAs switching fields. This feature alone makes the profession appealing to many. For some, it is also an exciting and rewarding aspect of the profession for the practicing PA to incorporate areas of interest into their active clinical careers or follow a non-clinical trajectory. For example, physician assistants may maintain their full-time patient care work and decide to become involved in research. They may elect to be part of a research team and incorporate their knowledge into study design and implementation, data analysis or become a contributing author to a published article.

PAs often participate in departmental projects and hospital-wide polices as key stakeholders given their presence and function in multidisciplinary care teams. Insight into patient care and hospital inner workings also presents opportunities for PAs to advance to positions within hospital administration. This presents a new and challenging area of practice for PAs with a passion to improve hospital delivered patient care and PA responsibilities. For example, Denni Woodmansee, PA-C, acting Director of Physician Assistant Services for the U.S. Department of Veterans Affairs, has been effective in creating policies to be more inclusive of PAs and to appropriately widen the scope of PA practice within the Veteran's Administration.

Physician assistants may become involved with one of the four major national PA organizations: the American Academy of Physician Assistants (AAPA), the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), the National Commission on the Certification of Physician Assistants (NCCPA) or the Physician Assistant Education Association (PAEA). The AAPA advocates for the PA profession on a local and national level. NCCPA is the only certifying body for physician assistants. PAs involved with NCCPA assist with ensuring that physician assistants meet professional standards and these core values and knowledge set are adequately assessed for in the NCCPA certifying examination. The work of the ARC-PA is geared towards reviewing current and new physician assistant programs to make certain they are meeting or exceeding previously identified professional, academic and clinical standards for newly graduating physician assistants.

The highly respected U.S. Public Health Service (USPHS) also enlists PAs as Commissioned Corps Officers and assigns them to areas of greatest need.³ In turn, they serve needy populations within the United States, while becoming part of a medical deployment team to offer medical care of persons affected by natural disaster or illness outbreak. Rear Admiral Michael Milner, one of the highest-ranking PAs in the USPHS, highlights the extensive ways in which PAs can contribute to medicine and public health. Rear Admiral Milner's career included managing public health programs in Rhode Island and five additional states, working for the Department of Homeland Security, becoming

Chief Professional Officer for the Health Services Office and acting as Chief PA consultant to the Director of the Indian Health Service (IHS).⁴

PAs work in a multitude of environments. This flexibility extends to work outside of the United States. Due to the predicted physician shortage and challenges with providing accessible and affordable health care, the need for advanced care providers on the global scale has been recognized. The model of education provided to PAs in the US serves as a benchmark for other countries to establish similar programs in their home locales to give rise to semi-autonomous clinical workers with the potential to address current health care delivery obstacles.⁵ Recently, the United Kingdom began the National Physician Associate Exchange Program, employing U.S.-certified Physician Assistants in the United Kingdom in an effort to expand the role of Physician Associates working with the National Health System in England.⁶ Canada, Australia, New Zealand, Northern Ireland, Scotland, the Netherlands, Germany, Ghana, Afghanistan, Liberia, Israel, Saudi-Arabia, India and Taiwan have already begun training and graduating physician assistants/physician associates. This list does not include those countries that have established their own version of an advanced practice provider that is not necessarily given the title of physician assistant or physician associate.⁷ The increasing presence of PAs around the globe has opened the door for international clinical work within those countries that welcome certified US physician assistants to be part of the clinical team.

The areas of interest and career paths discussed here are not completely representative of the pathways available to PAs; however, they represent a small portion of the wide variety of possibilities that exist for PAs today. With the projected growth of the PA profession comes an expanding pool of clinical and non-clinical jobs that will allow PAs to offer expertise, education and guidance as valued members of health care teams in the United States and abroad.

References

1. State of Rhode Island Department of Health. Physician Assistant Licensure. 2018. Accessed at: <http://health.ri.gov/licenses/detail.php?id=237#three>
2. State of Rhode Island Department of Health. Physician Assistant Licensure. 2018. Accessed at: <http://health.ri.gov/licenses/detail.php?id=237#three>
3. Commissioned Corps of the U.S. Public Health Service, U.S. Department of Health and Human Services. 2018. Accessed at: <https://www.usphs.gov/aboutus/>
4. Carter R. RADM Michael R. Milner, DH. Sc, PA-C. Physician Assistant History Society, Johns Creek, GA. Accessed at: <https://pahx.org/assistants/milner-michael/>
5. Hooker RS, Hogan K, Leeker, E. The globalization of the physician assistant profession. *J Physician Assistant Education*. 2007;18 (3): 76-85.
6. National Health Service. The National Physician Associate Expansion Programme. 2018. Accessed at: <http://npaep.com/>
7. Cobb, N. A Call to Action, Accelerated Medically Trained Clinicians and the Social Determinants of Health. 2015. Accessed at: <http://whoeducationguidelines.org/blog/call-action-accelerated-medically-trained-clinicians-and-social-determinants-health>.

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Why Hire a PA?

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The Physician Assistant (PA) profession is growing rapidly and was recently cited as the third best job in America in 2018.¹ PAs partner with physicians to improve patient-centered and integrated care and add value to their respective clinical teams. Their presence in a practice increases access to high quality care, which improves both productivity and revenue for practices and their respective physicians.² To gain a better understanding of why physicians choose to incorporate PAs into their practice, we examined the experience of a small primary care practice and a larger orthopedic group in Rhode Island. Physicians and PAs in each setting provided a practical, hands-on perspective on how they define PA roles, negotiate clinical autonomy, and coordinate care with other members of the practice. We interviewed Dr. John K. Czerwein, Jr. and PA Benjamin Javery of The Center for Orthopaedics, Inc. (CFO) as well as Dr. Herbert J. Brennan and PA Kimberly Masood of Brennan, Cronin, and Peters: Internal Medicine practice (BCP) to obtain perspectives about PA roles and contributions in different settings.

Practices typically consider adding a PA when rising demand exceeds their ability to provide quality care to all their patients.³ Physicians may recruit additional physicians, or hire a Nurse Practitioner (NP) or PA. Bringing an additional physician into a practice is often less cost-effective than adding non-physician practitioners because a new physician would receive a larger salary and often own a share in the practice.⁴ While NP and PA roles can overlap, there are key differences between the two professions. NPs are trained using a nursing model, focusing on health promotion, disease prevention, and counseling.⁵ PA education was shaped by several prominent academic physicians, who recognized that medical corpsmen returning from the war in Vietnam had strong, but underutilized clinical skills.⁶ Before entering PA school, applicants must complete between several hundred to 2000+ hours of direct patient care experience, providing future PAs with a hands-on approach to patient care before beginning their studies. "The intensive PA curriculum is modeled on that used in medical schools."⁷ In a typical 27-month program, PA students must complete over 2000 hours of supervised clinical practice in a wide variety of settings that includes rotations in family medicine, internal medicine, general surgery, pediatrics, obstetrics and gynecology, emergency medicine and psychiatry.⁷ In contrast,

the Executive Director of the New Hampshire Nurse Practitioner Association noted that "NPs approach patient health care by looking at the patient as a whole, by looking at their social needs as well as their medical needs. They bring a more holistic approach to treating the patient."⁸ This holistic philosophy leads NPs to "function as a combination of a patient educator and a social worker."⁸ These differences in education make it more likely for PAs to specialize, while NPs are more common in a primary care setting.⁹

HIRING A PA

At the Center for Orthopedics (CFO), "We did consider a nurse practitioner as a possible hire, but based on the research we did, we felt that a physician assistant would be more advantageous in the operating room." PAs are exposed to multiple surgical specialties during their required rotations, and their curriculum, akin to medical school, reflects a more "disease specific" orientation. In contrast, more than 90% of NPs train in primary care, and NPs are more likely to choose careers in primary care settings.⁹ In this context, the Center for Orthopedics' decision to hire a recent graduate of a PA program filled an important need for the practice to add a colleague who would be ready to assist in surgery rather than spending most of his time in the clinic. One of the most challenging problems for CFO was managing surgical patients in Providence while also seeing patients in the outpatient clinic in Johnston. Surgeons in the practice perform surgeries at Our Lady of Fatima Hospital and also see patients for outpatient visits in Johnston. Providing continuity of care proved difficult due to the distance between sites. The use of a PA "reinforces continuity for patients when their usual provider is not available" and has "decreased stress" and "significantly reduced [the surgeons'] workload."¹⁰ As the American Association of Surgical Physician Assistants noted, "surgical PAs can be indispensable in an office setting, performing about 80% of the tasks normally performed by physicians," including preoperative exams, post-op wound checks, and the removal of sutures, staples and drains.¹¹ In hospital settings, PAs can order labs, imaging studies, EKGs, and necessary medications.¹¹ This team-based patient-centered care helps patients build relationships with the entire team of providers knowing that they will always have available support and consultation to discuss treatment plans and track progress.

PAs may also play a vital role in primary care settings. The continuing shortage of primary care physicians creates significant challenges for practices seeking to expand their ability to meet patient demand.¹² The primary care practice of Drs. Brennan, Cronin and Peters (BCP) faced difficulty meeting the rising demand of their patients. The partners considered hiring a new colleague to manage their increasing volume of patients and the challenge of providing same-day visits for patients. Since unscheduled appointments are difficult for primary care practices to balance, hiring a PA expanded the ability of the practice to see more patients without further overextending the physicians. Most practices face pressure to shorten the length of patient appointments to accommodate more patients. Recent estimates predict a shortage of between 4,300 and 43,000 primary care physicians nationally by 2030.¹³ Hiring a PA allowed BCP to uphold their patient-provider relationships while increasing availability. As a recent graduate, BCP felt she was a good addition to the care team because they could mold her skills to fit the practice's patient care philosophy.

Hiring a PA rather than a partnering physician often makes financial sense for a practice, as the salary difference between physicians and PAs in primary care is roughly \$89,000.¹⁴ For an internal medicine practice such as BCP, Dr. Brennan noted that either a PA or an NP offered effective options. NPs are growing in primary care because they can be independent providers; 20 states (including Rhode Island) grant NPs "full practice authority" to diagnose and treat patients without physician supervision.⁹ The proportion of PAs choosing careers in primary care has steadily declined since the mid-1990s because a majority of job postings for PAs were in surgery (28%), emergency medicine (12%), or other specialties.¹⁵ Nevertheless, PAs represent an excellent option for primary care practices since they are trained as "generalist clinicians who are ready to practice medicine in collaboration with a physician."¹⁶ Although BCP chose to add a PA to meet the needs of a growing practice, Dr. Brennan believes the PA and NP roles can be interchangeable if the applicants are "properly trained" for their respective setting.

SCOPE OF PRACTICE

In Rhode Island and 19 other states, NPs are licensed to practice independently; in other states, their scope of practice varies widely. Unlike NPs, PAs must practice under a supervising physician. The nature of this supervision, however, is defined by each physician and PA independently. PAs acquire new skills over time as they gain experience through supervised practice. "Upon graduation, a PA is an adaptable provider. Akin to a stem cell, the PA has the flexibility to move into any specialty practiced by a supervising physician."¹⁶ The ability to change specialty or area of practice as a PA is possible because of a PA's relationship with his or her supervising physician. More than 50% of PAs practice will practice in more than one specialty during their career.¹⁶

As one PA at the Center for Orthopaedics noted, staying in Rhode Island allowed him to have many "freedoms provided such as no restriction on prescribing different classes of medication and flexibility with regard to physician supervision."

The PA role is defined by negotiated autonomy with their supervising physician. The Department of Health's rules and regulations for the licensure of physician assistants specify that "Physician assistants practice with physician supervision. Physician assistants may perform those duties and responsibilities consistent with the limitations of §5-54-8 of the Act, including prescribing of drugs and medical devices, that are delegated by their supervising physician(s)." The PA's level of autonomy, in turn, depends on the "experience, training and preferences of all providers on the team, the needs of the patient population and the level of trust the physician has with the PA." Dr. Czerwein noted that a PA's scope of practice can expand over time. For example, during his first six months at the Center for Orthopaedics, the PA's responsibilities in the operating room went from observing to assisting on some cases, to first-assisting in surgery. Dr. Brennan's description of a PA's role and negotiated autonomy focused on the patient. When a PA is first hired, he or she needs to acclimate to the specific clinical setting, as primary care treatment modalities vary widely. As PAs adjust to their new roles, their "clinical acumen" also grows, which gives the supervising physician confidence in how the PA is fulfilling his or her new role.

FINANCIAL CONSIDERATIONS

The PA profession continues to expand; the number of PAs in practice is expected to grow 38% between 2012 and 2022.¹⁷ Many factors contribute to a student's decision to become a PA rather than applying to medical school. PAs represent a cost-effective option for growing physician practices. The 2016 Statistical Profile of Certified Physician Assistants by Specialty Annual Report states that Surgical Subspecialty PAs made an average of \$113,496 while Primary Care PAs made an average of \$95,928.¹⁸ In contrast, according to the Medscape Physician Compensation Report, orthopedic physicians made on average \$489,000 while family medicine physicians made an average of \$209,000 in 2017.¹⁹ These large pay gaps, especially in surgical subspecialty like orthopedics, can offer a compelling case to hire a PA.

CONCLUSION

The experience for both the Center for Orthopaedics, Inc. and Dr. Brennan, Cronin and Peters' Internal Medicine practice demonstrates how PAs can improve the efficiency of different practice settings. The PA profession was designed for flexibility, adaptability, and negotiated autonomy. In a rapidly changing health care system, PAs can increase work productivity, reduce physician stress, and support a team-based, patient-centered model of care while presumably maintaining or increasing quality of care.

References

1. US News and World Report. The 100 Best Jobs in America 2018. Accessed at: <https://money.usnews.com/careers/best-jobs/rankings/the-100-best-jobs>.
2. American Academy of PAs. Hiring A PA. Accessed at: https://www.aapa.org/wp-content/uploads/2017/01/Hiring_a_PA_2017_April_2017_update.pdf.
3. American College of Physicians. Hiring a Physician Assistant or Nurse Practitioner. Accessed at: https://www.acponline.org/system/files/documents/running_practice/practice_management/human_resources/panp2.pdf.
4. National Association of Locum Tenens Organizations. 3 Benefits PAs Have Over Physicians. Accessed at: <https://www.nalto.org/3-benefits-pas-physicians/>.
5. Erikson AB. Should you hire an NP or PA for your facility? Accessed at: <https://weatherbyhealthcare.com/blog/hire-np-pa-facility>.
6. Dehn RW, Everett CM, Hooker RS. Research on the PA profession: The medical model shifts. *JAAPA*. 2017; 30 (5): 33-42.
7. American Academy of Physician Assistants. PA Education - Preparation for Excellence. Accessed at: https://www.aapa.org/wp-content/uploads/2016/12/Issue_Brief_PA_Education.pdf.
8. Garret V. Nurse practitioners and physician assistants: Why you should hire one (or the other). Accessed at: <https://www.softwareadvice.com/resources/nurse-practitioners-physician-assistants-why-you-should-hire/>.
9. Van Vleet A, Paradise J. Tapping nurse practitioners to meet rising demand for primary care. Kaiser Family Foundation Issue Brief (January 2015). Accessed at: <http://files.kff.org/attachment/issue-brief-tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care>.
10. American Academy of PAs. PAs and Team Practice. Accessed at: https://www.aapa.org/wp-content/uploads/2016/12/Issue_Brief_Team_Practice.pdf.
11. American Association of Surgical Physician Assistants. Why you should hire a surgical PA. Accessed at: <http://www.aaspa.com/why-you-should-hire-a-surgical-pa>
12. Bodenheimer TS, Smith MD. Primary care: Proposed Solutions to the Physician Shortage Without Training More Physicians. *Health Affairs*. 2013; 32 (11). Accessed at: <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0234>.
13. Mann S. Research Shows a Shortage of More Than 100,000 Doctors by 2030. Accessed at: <https://news.aamc.org/medical-education/article/new-aamc-research-reaffirms-looming-physician-shor/>.
14. MidlevelU. PA vs. MD Salaries: State-by-State Comparison." <https://www.midlevelu.com/blog/pa-vs-md-salaries-state-state-comparison>.
15. Morgan P, Leach B, Himmerick K, Everett C. Job openings for PAs by specialty. *JAAPA*. 2018; 31 (1): 45-47.
16. Hass V. Physician Assistants and Nurse Practitioners are not interchangeable. *JAAPA*. 2016; 29 (4): 9-12.
17. Moran B. The Physician Assistant Will See You. Accessed at: <https://www.nytimes.com/2014/08/03/education/edlife/the-physician-assistant-will-see-you.html>.
18. National Commission on Certification of Physician Assistants. 2016 Statistical Profile of Certified Physician Assistants. Accessed at: <http://www.nccpa.net/research>.
19. Grisham S. Medscape Physician Compensation Report 2017. <https://www.medscape.com/slideshow/compensation-2017-overview-6008547#23>.

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