No Longer Invisible: Challenges to PA Education
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A key characteristic that has made physician assistants (PAs) so valuable in the US health workforce is their adaptability. PAs have been termed “medical workforce stem cells”—a reference to their ability to work with physicians in almost any clinical practice setting. Over time they have also been able to adjust to the changing demands in the health care system and fill niches in the medical workforce. Physicians are beginning to appreciate this capability. After a period in which PAs were, to use a telling term, “invisible” on the health workforce policy scene, influential leaders in medicine have recently taken note of their current roles and future potentials.

In recent editorials in this and other journals, three physicians have observed impending trends in medical care delivery and have set forth the implications, as they see them, for the PA profession. In their analyses of health workforce trends, these leaders deliver direct challenges to the PA profession and to PA education, and pointedly suggest changes in the professions’ educational direction and structure. I’d like to address these challenges in turn and also pose a larger question for PA educators and the Physician Assistant Education Association (PAEA).

Length of Training
In the first article (published in volume 18, number 1 of this journal), Michael Whitcomb, a former medical school dean and the outgoing editor of Academic Medicine, suggests that in light of likely future trends in the health sector, PA education may need to rethink, among other things, its current length of training. It is his belief that PAs (and nurse practitioners) are likely to assume an expanding role in medical care in the future. His assumption, based in part on his view that the physician workforce will not be able to meet the anticipated future demand for medical care services, is that “PAs will assume an expanded scope of practice in which they take on new responsibilities for patient care.”

First, he asked whether “one year of clinical training is still adequate preparation for PA practice in primary care settings?” This is an entirely reasonable question given the increasing complexities of modern medicine and the difficulties faced by primary care providers in patient management. It is easy to understand how individuals outside of the PA profession may feel that two years is a relatively short time in which to prepare for encountering the wide range of clinical problems faced by modern clinicians. Moreover, the recent discussion of PA specialty recognition and certification has called attention to additional realities, such as the prevalence of younger and less experienced new PA graduates, increasing rates of specialization, an increase in the number of PA postgraduate programs, and greater scrutiny of credentialing and regulatory agencies—all of which raise legitimate questions regarding the adequacy and depth of current PA education.

Many in PA education, however, would be reluctant to further lengthen PA training, the average length of which has now crept up to 26 months. One key concern is that if the average 22-month gap between the lengths of PA training and that of medical school were further reduced, to say, one year, qualified candidates may be more willing to select medical school over PA training. The suggestion to lengthen training could strengthen the case for a greater role for PA postgraduate residency training, particularly in intensive and high-technology specialties such as some of the surgical subspecialties, emergency medicine, and critical care. The issue of program length is one that bears further examination.

PA Program Expansion and Other Changes
Another issue raised by Dr. Whitcomb is organized medicine’s recent move to expand the output of US medical schools. The prevailing wisdom in health workforce policy circles, one shared by Whitcomb, is that medical schools must expand their capacity in order to meet the anticipated demand for physician services in the next 10 to 20 years. This projected demand is based on the assumptions of an expanding and aging population, decreased physician productivity, and an increasing US gross domestic product. Whitcomb predicts that even the 30% increase called for will be inadequate to meet the anticipated demand for medical care services and that the system will require a strong contribution by nonphysician health care professionals to meet these needs. He suggests that PA programs should consider increasing their output of graduates. Others are making the
same suggestion, which I will address further below.

Somewhat troubling is Whitcomb’s intimation that PA education is best conducted when training programs are directly affiliated with a medical school or academic health center. Based on the same assumption as in the suggestion to increase training length — that PAs will need to pick up some of the slack created by a shortage of physicians in the workforce — he asks: “Should all PA programs be required for accreditation purposes to have a meaningful affiliation with a medical school or academic health center?”

There are at present about 50 PA programs sponsored by entities meeting the definition of an academic health center (AHC) — ie, possessing a hospital, a medical school, and at least one other health professions school. In several instances, Whitcomb hints that the remaining programs — a majority — may need to rethink their institutional sponsorship. This suggestion does a disservice to the many programs set in non–academic health center settings that have successfully trained thousands of PAs. Is it possible that in this instance, Whitcomb reveals a lack of familiarity with the success of PA education?

A tenet of PA education long embedded in the accreditation system and proven successful over the past 40 years is that the preparation of competent clinicians can be accomplished in nontraditional settings for medical education — such as liberal arts colleges, universities, and community colleges — provided that they utilize effective affiliations with teaching hospitals and clinics. The demonstration that PAs have been effectively trained in settings other than the traditional medical school or academic health center setting makes it unlikely that his suggestion would be taken seriously or have much of an impact on trends in PA program sponsorship.

While some of Whitcomb’s suggestions for PA education strike me as being unrealistic, his underlying message to PA leaders and educators is an important one. He reminds us that public perceptions of the setting and extent of PA training are important and that the quality of our present and future graduates will greatly affect the nature and scope of practice activities. The health care environment is indeed changing, and will call for an increasing contribution from PAs. This in turn will increase the pressures for PAs to have a level of training and competency that meets the expectations of employers and patients in the medical care system.

In an editorial in this issue, Lynne Kirk, the immediate past president of the American College of Physicians (ACP), discusses a new model for primary and principal care — the patient-centered medical home (PCMH) — put forth by prominent medical professional organizations such as the ACP, the American Academy of Pediatrics, and the American Academy of Family Physicians. In this model, patients choose to receive their care from a medical practice that serves as their medical home.

Kirk’s message to PA educators is that, just as the care model, especially for chronic disease, needs to be reconfigured into the PCMH, educational approaches needed to train clinicians to function in the medical home model would need to be developed. Ideally, such an educational model would promote teamwork and emphasize shared responsibility and accountability among the professionals on the team. In training physicians, PAs, and other professionals for the PCMH, more time in the curriculum will need to be devoted to systems-based care, practice-based learning, professionalism and communication and interpersonal skills. We should monitor with interest the PCMH pilot projects and consider curriculum modifications related to this vital concept.

The third leader in medicine speaking to the PA profession is Richard Cooper, the leading advocate for the expansion of the health workforce. Cooper believes that we are facing a substantial physician shortage and that US workforce policy should call for an increase in the output of medical school graduates, nurse practitioners (NPs), and PAs. Speaking of both PAs and NPs, Cooper unequivocally asserts that “neither discipline has expanded its training capacity to the degree that will be required, and, like physicians, neither will have a supply of practitioners that will meet future demand.”

A key question for the PA educational community related to the suggestions of both Cooper and Whitcomb is: Is there any consensus on the need to increase the number of PA graduates, and if so, how should that consensus be expressed? In an attempt to answer the first part of that question, PAEA conducted surveys in 2006 and again in 2007 to assess the degree of planned PA program expansion. Nearly half of responding PA programs in 2006 stated that they “definitely” or “probably” would increase their class size or already had done so. This is roughly the same proportion seen among medical schools. However, the Association of American Medical Colleges has unequivocally and publicly called for an expansion of medical school graduates. Should PA education consider a similar policy?

**PA Educational Policy**

It is heartening to observe that after a long period in which medical leaders
showed scant interest in PA education, there is now increased attention being paid to PA educational policy and the roles that PAs can play in the health workforce. These challenges to the PA educational sector, however, present several tough issues. As mentioned, a key question is whether or not the PA profession should expand its output of graduates.

In terms of the workforce policy world, this last question is an important one. Leaders in medicine are essentially saying that they are counting on PAs to pick up a proportion of the slack in the workforce and that we need to consider raising the output of educational programs, as medical schools are doing. In an attempt to determine the dimensions of current program expansion plans, PAEA has conducted surveys, appropriately so. But thus far, little has been done with that information in response to calls for a greater supply of PA graduates, in terms of policy direction. So an even more basic question arises: Who determines PA educational policy? Is it our professional organizations or is it left to individual institutions? What is the role of PAEA in shaping PA educational policy?

Recent history suggests that it is market forces in higher education, rather than a concerted effort by the profession’s organizations, that tends to set the course of PA education. This was certainly the case in the second phase of PA program expansion that took place in the late 1990s (the first was the initial growth of programs in the 1970s generated by federal funding) when the number of programs more than doubled. In this instance, the professions’ organizations refrained from taking any public positions on program expansion and over the years PAEA has traditionally not taken official positions on workforce policy issues. However, times are changing. In view of the recent challenges presented to PA education by prominent leaders in medicine, the time may have come for a more assertive organizational approach to addressing PA workforce policy issues. It is time for us to take a more proactive role in shaping the direction of the profession.

REFERENCES
1. Davis A. AAPA Legislative Watch. 2006: June 16.