Stakeholder Feedback on the Regulation of Physician Assistants under the *Regulation Health Professions Act*, 1991 (RHPA)

Responses from Individuals

Note:

The responses below have not been edited by the Health Professions Regulatory Advisory Council (HPRAC). They are taken directly from the Online-Survey Questionnaires and Feedback Forms. HPRAC is not responsible for any errors and omissions found on the submissions; such errors and omissions are attributable to the relevant responder. The stakeholder comments are posted according to access to information guidelines (for guidelines visit, http://hrpac.org/en/privacy.asp)

Health Professions Regulatory Advisory Council (HPRAC)

Ontario
Health Professions Regulatory Advisory Council
Conseil consultatif de réglementation des professions de la santé

Physician Assistants: The Need for Professional Regulation in Ontario

(Working Paper: Evidence Brief)

1. Bachelor of Health Sciences (Hons.) Candidate 2012, 2. Degroote School of Business, Centre For Health Economics and Policy Analysis

Background

In 2003, the Canadian Medical Association (CMA) board of directors unanimously endorsed and approved a submission from the Canadian Association of Physician Assistants to become a designated health science profession. As a result, the Canadian Forces, Medical Services School in Borden, Ontario, became the first accredited Physician Assistant educational institution in Canada. Subsequently, its graduates were eligible to write the certification examination under the Physician Assistant Certification Council of Canada (PACCC). Since then, legislation for physician assistants (PAs) to practice has been formalized in Manitoba; while Ontario, New Brunswick, British Columbia and Alberta have recognized PAs in various policy statements or initiatives. As of 2010, there were 285 PAs serving in Canada and with increasing recognition and policy changes that number continues to grow (Jones 2011).

The development of a formal process for accreditation has improved the status of the PA role in Canada and created an avenue through which PAs can be trained and used to meet various needs within our healthcare system. The decisions on healthcare in Canada however, remain largely the control of individual provincial governments and the regulation of healthcare providers is often an ongoing negotiation between the province, respective stakeholders, and health professional organizations. Thus, the clarity of the PA role in maintaining the health of Canadians still remains unclear. In 1999, Manitoba became the first province to formally recognize "clinical assistants" under the Manitoba Medical Act, and in 2008 the University of Manitoba opened its first civilian PA education program.

In 2007, Ontario began a PA demonstration project to assess the use of PAs in community health centres, family practice teams, surgery services, endocrine and diabetes specialty clinics, rehabilitation centres, and emergency departments (EDs) across Ontario. In 2008, McMaster University began training its first cohort of PAs, and two years later the Consortium for PA education (the University of Toronto in Ontario, the Michener Institute for Applied Health Sciences in Toronto, and the Northern Ontario School of Medicine in Sudbury, Ontario) also began preparing students to be eligible to be certified under the PACCC. Discussion remains as to whether PAs should be regulated and how they would be regulated under the Regulated Health Professions Act (RHPA), 1991. To inform this debate on the ideal model of regulation for PAs under the RHPA this analysis will attempt to address the following questions:

1. What does the current body of research evidence state about the introduction of Physician assistants into a healthcare model with regards to increasing cost-effectiveness, quality of care, and access to timely care?

2. Within the criterion set out by HPRAC in the application for professional regulation, what should the Ontario Ministry of Health consider with regards to regulating physician assistants in Ontario?

Methods

As indicated by HPRACs application guide, the type of evidence produced from this research is classified as expert knowledge. In order to inform this process, the first phase of the analysis consisted of a review of the current literature on PAs using the critical interpretative synthesis. The systematic review drew on sources of peer-reviewed and grey literature exclusively from developed countries, and included specific submissions from professional associations and colleges to HPRAC and documents from provincial governments and other relevant organizations. All phases of the literature search was conducted using NRC

National Science Library (Canada), PubMed, CINAHL, Google Scholar, and Web of Science electronic bibliographies. The initial search using the terms "Physician Assistant" underwent a title and abstract review for "access to care", "quality of care" and "cost-effectiveness" which resulted in an initial sample of ten papers. Phase two consisted of individual searches with the original search term as well as the three aforementioned key terms with a specific focus on primary studies and evidence-based papers as opposed to opinions and editorials which generated twenty one entries. From reviewing these papers the third phase attempted to find articles on physician assistants specific to "rural healthcare", "inter-disciplinary teams", "interprofessional teams" and "Canada" which generated thirty-seven papers.The final judgement about inclusion of the review rested both on an assessment of our relevance criteria as well as on the assessment of the quality of the individual papers.

Key themes identified from this literature search include increasing access to care for patients, quality of care and cost effectiveness, as well as the role-specific use of PAs and their potential use in rural areas. Furthermore, the review provides an historical overview of the PA role in Canada and the development of and amendments to the Regulated Health Professions Act, 1991 in Ontario as it pertains to the professional regulation of PAs.

To follow up on the findings of the literature review the final part of the analysis included key informant interviews with physician's assistants, nurses, physicians, other healthcare professionals ,hospital administrators and policy-makers who would have either a interprofessional relationship with PA's in patient care or have a key stakeholder position in terms of knowledge and policy implications of the PA role.

TABLE 1.

Stakeholders	Stakeholder Role	Number of Stakeholders
1. Healthcare Workers	Physician Assistants (Primary Care)	2
	Physician Assistant (hospital setting)	4
	Physician Assistant Candidates	2
	Physicians (primary Care)	1
	Physicians (Hospital Setting)	2
	Other Healthcare Professionals (NP,RN etc.)	1
2. Hospital Management	Clinical Directors	2
3. Education and Policy	PA Education Program McMaster University	2
	Health Services Research	1
TOTAL		**n = 17**

The review of evidence aided in the development of questions which elicited the opinion of stakeholders on efficiency, increasing access to care for patients, quality of care, cost effectiveness and regulatory models with regards to the PA role. Interviewees were recruited using the snowballing technique. All of the interviews were transcribed using Dragon Naturally Speaking 11 software and reviewed by the principal investigator to ensure consistency. Qualitative analysis was conducted using nVIVO 8 to determine significant themes that emerged from the data which addressed the research questions. Through a content analysis the findings were used to determine the beliefs and opinions of healthcare stakeholders concerning the role of the PA. These qualitative interviews helped to corroborate, or find discrepancies, between the

purpose of regulation as defined by HPRAC, the submission by the Canadian Association of Physician Assistants, and the opinions of PAs, Physicians and other Stakeholders.

This work combines a review of the literature, along with qualitative information gathered from key informant interviews. The analysis is purposefully Canadian and specifically Ontario focused and is designed to assess the need for regulation and if so potential models of regulation through a discussion of the professionalization of other healthcare roles, professional equitability, large stakeholders and Ontario's health human resource planning.

Preliminary Findings

1. The unique PA-Physician relationship challenges the dynamic of interdisciplinary teams and presents the risk of developing new "silos" within the healthcare continuum.

- The scope of practice of an individual PA is typically controlled by the individual physician with whom they work. PAs may therefore experience limited opportunities to transfer to a different healthcare setting.

- Interaction between PAs and other members of the health care team are often mediated through the physician which may result in conflict. For example, a pharmacy may refuse to accept a prescription written by a PA even though the authority to do so has been delegated by a physician.

2. It is unclear whether the role of the PA will increase the efficiency of Ontario's healthcare system.

- It is unclear whether early PA adopters(employers) will continue their commitment to the PA role without continued government financial support.

- In some situations, physicians bill for services provided by the PA who is under their supervision. As a result, the system cost of being seen by a PA is equivalent to that of being seen by a physician.

- Much of the evidence on cost-effectiveness pertains to the American and British settings and is therefore difficult to apply to the Ontario setting.

- The roles and effective use of all health human resources should be considered in determining the best mix of health care providers.

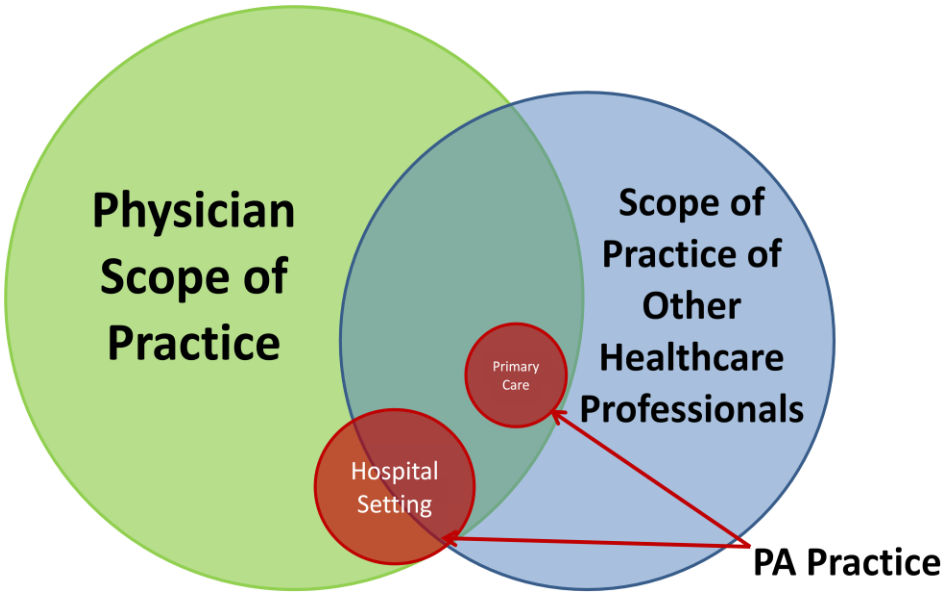
- A considerable amount of resources are required to train a PA to serve within a specific healthcare setting (beyond that which is provided in the PA programs). Furthermore, some individuals who are being trained as PAs come from other health professions meaning that costs have been incurred to train these individuals twice.

3. The various settings in which PAs serve make it difficult to standardize and define the PA scope of practice.

- There is a need for role clarity with regard to the PAs (especially in the hospital setting). Without a standardized scope of practice, high physician turnover in hospital settings present efficiency barriers as the PAs role may be altered based upon the expectations of the physician with whom they work.

- There is a significant overlap between the delegated tasks to a PA and those performed by other healthcare professionals both in primary and hospital settings.

Figure 1.



- The red circles represent examples of PA practice. PA practice is always within the scope of practice of the physician but it varies greatly according to the healthcare practice setting and the PAs relationship with their supervising physician.

- In these examples drawn from our expert knowledge interviews, PAs working in the primary care setting did not perform any roles outside the scope of practice of other healthcare professionals. PAs that worked in the hospital setting recalled performing tasks that were in both the scope of practice of other healthcare professionals and only in the scope of practice of the supervising physician.

-Where PA practice overlaps with the scope of practice of other healthcare professions an evaluation of the roles and effective use of all health human resources use should be considered. The situations in which PAs practice only overlaps the scope of practice of physicians a practice "niche" is established for a PA.

4. The body of knowledge provided by the PA education program is often insufficient for immediate entry to practice.

- Stakeholders noted that the integration of PAs into their healthcare setting faced many implementation barriers. Some of these barriers included the need to clarify roles in the practice setting and the development and revision of medical directives.

- A significant amount of resources are required to train PAs to work within a specific healthcare setting. For example, some hospitals require up to a year of additional on-the-job training for PAs after their graduation from a PA program and other healthcare professionals need to be educated on the PA role.

Conclusions

It is important to frame the preliminary analysis of these expert knowledge interviews by the question set out by the current ministerial referral to HPRAC on PAs:

> **"... consider whether this profession ought to be regulated, whether independently or in conjunction with an existing profession...what model of regulation, if any, is most conducive to interprofessional collaboration, In evaluating potential models of regulation, consider what factors would support effective future collaboration between PAs and other health professions in Ontario."**

The answer to this question is dependent on the objectives for the implementation of PAs into Ontario's healthcare system. Strictly speaking, the controlled acts delegated to PAs are the responsibility of the supervising physicians who are already regulated under the College of Physicians and Surgeons of Ontario (CPSO) and therefore the public is protected through the delegation model.

A lack self-regulation for PAs acts as a barrier to innovation and the government's ability to increase the efficiency of the healthcare system since the use of PAs is restricted by an individual physicians' willingness to delegate controlled acts and the CPSO's willingness to permit independent practice. Regulation under the CPSO would allow physician interests groups to control and determine the PA role. A commitment to increasing access to care and efficiency in the healthcare system begins with the proper establishment of healthcare roles and effective use of health human resources. Self-regulation for the PA profession ensures public protection and presents greater opportunities for increasing efficiency.

Based on our analysis there are some merits to allowing "self" regulation. However, the added benefits of professional regulation through the CPSO seem to accrue primarily to the medical profession rather than the public at large.

References

Jones, I.W. & Hooker, R.S., 2011. Physician assistants in Canada: update on health policy initiatives. *Canadian Family Physician Médecin De Famille Canadien*, 57(3), pp.e83–88.

Please note that these results are preliminary and that the full results will become available in April

.

Health Professions Regulatory Advisory Council
56 Wellesley St. West 12th Floor
Toronto, Ontario, Canada
M5S 2S3

Telephone: 416-326-1550
Toll-Free: 1-888-377-7746
Fax: 416-326-1549

Website: **www.hprac.org**

Email: **hpracwebmaster@ontario.ca**