What Is A Physician Assistant?

Physician assistants are highly trained medical professionals who have completed an intensive medical education designed to prepare them to provide a variety of medical services. The American Academy of Physician Assistants defines physician assistants as:

“healthcare professionals licensed.... to practice medicine with physician supervision. As part of their comprehensive responsibilities, PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and write prescriptions. Within the physician-PA relationship, physician assistants exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services. A PA’s practice may also include education, research and administrative services” (AAPA).

As part of a physician-directed team, PAs have been shown to provide quality of care comparable to that of a physician (Office of Technology Assessment, 1986; Sox, 1979) while improving the cost effectiveness of a medical practice (MGMA, 1996). Additionally, PAs have been shown to be able to care for most patient problems seen in the primary care context (Hooker, 2003; Office of Technology Assessment, 1986; Record, 1980) and are utilized clinically in nearly all medical and surgical subspecialties.

Physician Assistants – The Past


As of 2013, according to the Physician Assistant History Society, more than 105,000 physician assistants are certified to practice medicine and more than 90,000 are actively practicing. As of 2014, there are more than 180 accredited educational programs for training PAs. Fifty years ago (1963) this profession did not exist and there were no training programs. How did this profession emerge?

Advances in medical science following World War II led to a sharp increase in physician specialization at the expense of the broader
practice of what would be called “primary care.” Although two national commissions were convened, resulting in recommendations that led to the creation of the new specialty of Family Medicine and the development of sections of General Internal Medicine and General Pediatrics within those academic departments, the intrinsic length of medical education precluded any effective rapid deployment. Additionally, the shortage of generalist physicians was compounded by the creation of Medicare and Medicaid, opening access to health services by millions of new patients.

At the same time, a number of leaders began to articulate what most physicians already knew: much of what the doctor does each day could be carried out by specially trained non-physicians, working alongside doctors as part of a team. Most physicians were already training office personnel to do more than answer the phone and schedule patients. In the “back office” they took vital signs, gathered information, and even performed minor procedures. In developing countries, non-physicians had been doing this, and more, for centuries.

In the early 1960s was the example of the United States military corpsmen who, with only a few months of training, were highly successful in managing battlefield injuries and illnesses. Their vital skills were lost to society when the corpsman was discharged from military service. Physicians wanted to harness these skilled corpsmen to serve the civilian population following their military service.

**Development of Training Models and Formal Education**

At Duke University in the late 1950s, Thelma Ingles, RN, took a sabbatical year from the nursing school to work with Eugene A. Stead, Jr., MD, Chair of the Department of Medicine to learn clinical medicine from him and his colleagues. Impressed with what nurses might be able to do, Ingles and Stead drew up a curriculum for “advanced clinical nursing” that would be offered to outstanding nurses who wanted to broaden their knowledge in a program leading to a Master’s Degree in Nursing. The program was launched successfully, resulting in nurse clinicians with skills previously unknown in nursing. Ingles and Stead eagerly applied to the National League for Nursing for accreditation.

To their stunned amazement this innovative program was rejected (twice). Two reasons given-first, there was too much physician
involvement in the curriculum, and second, Ms. Ingles lacked a baccalaureate degree in nursing (her baccalaureate was in English from UCLA; her nursing training had been in the outstanding three year diploma program at the Massachusetts General Hospital). An opportunity for socially useful nurse/physician collaborative education, which might have been emulated elsewhere, was lost.

In 1960, Charles Hudson, MD, an emerging leader in the AMA, delivered an address to the House of Delegates in which he proposed that returning military corpsmen be provided with training to enhance their already formidable skills in order to serve as assistants to practicing physicians. The proposal was enthusiastically received by the medical profession when it was published in JAMA.

Eugene Stead, M.D. Dr. Stead is considered to be the “father” of the PA profession. National PA Day is celebrated each year on his birthday, October 6. He died in 2005 at the age of 96. (Piemme, 2013)

Image courtesy of the PA History Society.
Thelma Ingles, RN., MA. Ingles worked with Dr. Stead to develop a curriculum for “advanced clinical nursing,” but their program was rejected twice. Stead leveraged their work to launch a course of study for corpsmen to become “physician’s assistants.”

Image courtesy of the PA History Society.

Stead at Duke was familiar to the concept of training non-physicians to provide medical care. At Emory University during World War II he used medical students (called “externs”) to provide medical care on the wards in place of interns and residents who had been drafted into military service. He was well acquainted with Amos Johnson, MD, a respected general practitioner in rural North Carolina, who had trained a young farm boy to be his assistant, and to treat patients in his absence when he was away. Stead had also observed former corpsmen working in the laboratories of his faculty colleagues, performing specialized procedures with patients. In 1964 Stead announced that he intended to create, the following year, a course of study for corpsmen to become “physician’s assistants.”

In 1965 four former Navy Corpsmen entered a two year program at Duke University that included nine months of training in basic medical sciences, and fifteen months of clinical rotations. Three of the candidates graduated two years later.

Concurrently in 1965, at the University of Colorado, Henry A. Silver,
MD, and Loretta Ford, RN, Ed.D, collaborated to develop a four month “Pediatric Nurse Practitioner” program, training skilled nurses to provide well baby care and manage the more common outpatient pediatric illnesses. Recognizing that much more of primary care pediatrics could be treated by non-physicians, Silver went on to create a two year program which, followed by a year of internship, led to the master’s degree as a “Child Health Associate.” He then worked closely with the state legislature to change the Colorado Medical Practice Act to permit these “Associates” to “practice pediatrics,” if working with, and under the supervision of a pediatrician. University of Colorado was also the first PA program to offer a master’s degree for the profession.

Image courtesy of the Duke University Medical Center Archives.
Richard A. Smith, MD, MPH, founder of the University of Washington PA program, received his medical degree from Howard University and an MPH from Columbia University. He committed himself to a career that would bring health services to underserved populations in both the United States and in developing countries. Two years with the Public Health Service on the Navajo Reservation in Arizona was followed by two years with the Peace Corps in Nigeria. After spending time in the Surgeon General’s office focusing on international health, he moved to the University of Washington where he developed the MEDEX concept in 1968. The program focused first on building the skills of former career military corpsmen, and then placing them in an apprentice relationship with a primary care physician in a rural location, in one of the four states in the upper Northwest.

Henry Silver, having co-founded the country’s first pediatric nurse practitioner program in 1965, also established the Child Health Associate (CHA) Program at the University of Colorado in Denver in 1969.

Image courtesy of the PA History Society.
An alternative to the Duke University model, the program in Seattle drew upon former career military corpsmen. Following only three months of formal instruction, the students were paired with rural practitioners in four western states, where they were expected to remain following graduation. He then helped replicate the MEDEX model in eight other medical colleges and, with colleagues, formed the Council of MEDEX Programs. Although these prototype programs ultimately recruited outside the military ranks, and expanded the biomedical science component of their curriculum to meet accreditation standards, they retained their focus on assistants to physicians providing care to underserved populations.

The programs developed at Duke University and at the University of Washington received national attention and were quickly emulated at several academic medical centers. Two important questions

Dr. Richard Smith, who established the first MEDEX program at the University of Washington to rapidly deploy ex-military corpsmen to rural primary care practices throughout the Northwest.

Image courtesy of the PA History Society.
Program brochure for the MEDEX program at University of Washington.

Image courtesy of the PA History Society.
remained: would the assistant to the physician be widely accepted by the medical community? Would states permit them to practice medicine, even under the supervision of a physician?

**Framing Effective Legislation for this New Profession**

States have traditionally regulated health occupations through the process of licensure whereby they grant permission to persons, meeting predetermined qualifications, to engage in an occupation and/or use a particular title.

The physician assistant emerged at a time when the system of licensure was being viewed by many as a means of protecting the
occupation from competition, rather than protecting the public from unethical or incompetent practitioners. The abuses of licensure were assailed by reports from both the American Medical Association and the American Hospital Association in 1970. The federal government agreed. The Department of HEW [Department of Health Education and Welfare] urged a moratorium on the licensing of new health occupations until improvements in licensing criteria could be made. The only alternative to licensure for the physician assistant was an amendment to the medical practice act, permitting the PA to work under the “supervision, control, and responsibility” of the licensed physician.

The first state to amend its medical practice act was California. Although a useful beginning, the legislation was flawed in two respects. First, it attempted to delineate the tasks that the PA was permitted to perform. Secondly, it added language detailing requirements of the programs from which PAs might graduate. With respect to the first issue, it was becoming apparent to educators that tasks that might be assigned to PAs were almost limitless. Far preferable was legislation that would permit the supervising physician to assign any task for which the PA had been trained providing that the task was within the scope of practice of the physician. Such “delegatory” amendments quickly became the standard for almost all of the states that followed. With respect to the educational standards, they were far better left to a recognized national body that could accredit programs.

**Accreditation of Emerging Physician Assistant Programs**

Following the pilot program at Duke University and the attendant favorable publicity, programs purporting to train assistants to physicians, exploded around the country. They varied in length from several weeks to four years. They were sponsored by proprietary companies as well as academic medical centers. A first attempt at rationalization was made by the National Academy of Sciences. PA Training was classified into three categories (Types A, B, and C) based on length and depth of training and on whether the program was intended to produce generalist or specialist assistants. While thought-provoking, the classification did little to address quality or identify specific programs in a useful way.
Accreditation is defined as the process by which an agency or organization evaluates and recognizes a program of study as meeting certain predetermined qualifications or standards. In 1971, in a manner similar to the criticism being leveled at licensure, the processes of educational accreditation were being charged with perpetuating a “credentials monopoly” in a report prepared for DHEW [Department of Health Education and Welfare] by Professor Frank Newman of Stanford University. The “Newman Report” urged that there was a need to “open up alternative routes to obtaining credentials.” The report was very useful in establishing the principles of accreditation and certification of PAs.

Upon urging from PA program directors and the Federation of State Medical Boards, the AMA took the lead in the accreditation of PA programs. The AMA had a long history of accrediting allied health education through its Committee on Allied Health Professions and Services. C.H. William Ruhe, MD, PHD, Director of Medical Education at the AMA, formed a committee that included representatives of specialty societies in internal medicine, pediatrics and family medicine, as well as the Association of American Medical Colleges. The product of deliberation was a document entitled, “Essentials for Educational Programs for the Assistant to the Primary Care Physician.” Adopted overwhelmingly by the House of Delegates in 1971, it led directly to the establishment of the Joint Review Committee for Educational Programs for the Assistant to the Primary Care Physician (JRC-PA). Accreditation of PA programs began in 1972.

Certification of Program Graduates

Certification is the process by which a non-governmental agency grants recognition to an individual who has met predetermined qualifications specified by that agency. It serves the public interest as a check on educational programs and the accreditation process and must be independent. In 1972, the National Board of Medical Examiners stepped forward to assume that responsibility. It was the first time the NBME had been involved in the examination of any health professionals other than physicians. The first examination was administered in December of 1973.

The NBME, a highly respected testing agency, was uncomfortable
with assuming the additional roles of determining which candidates might be eligible to take the examination and establishing the cut-off score that would qualify the candidate to practice as physician assistant. In 1974, in unprecedented collaboration, a meeting of 14 national organizations was convened by Malcolm C. Todd, MD, Chair of the AMA Council on Health Manpower, in order to establish a National Commission on Certification of Physician Assistants (NCCPA). Its charge would be to assume the roles of determining eligibility and standards for the examination and to issue certificates that could be used by the states to identify qualified PAs. The NCCPA had broad representation from relevant medical specialties, federal and state agencies, nursing, educational programs, and practicing PAs. It included public members as well, conforming in almost every particular to the criteria for legitimacy that had been articulated by the Newman Report.

PAs currently take the PA National Certifying Examination (PANCE) to become certified as a PA and the PA National Recertification Examination (PANRE) to continue their certification every 10 years.

**Organizing the Profession**

During the formative period of the late 1960s and early 1970s, two essential professional organizations were established. In April of 1968 the students and graduates of the Duke University program formed the American Association of Physician’s Assistants, incorporating it in North Carolina. Within three years the officers recruited membership from graduates beyond the local community, elected new leadership from around the nation and gained recognition as the sole voice for the profession. It became the American Academy of Physician Assistants.

Leaders of the early academic programs collaborated in 1970 to establish the American Registry of Physician’s Associates in order to recognize graduates of the “Type A” programs. By early 1972 it had become clear that both accreditation and certification were on the horizon. In April 1972, those pioneering programs, now numbering 14, decided to dissolve the Registry. Recognizing that they had common issues, they formed the Association of Physician Assistant Programs, allowing collaboration on such matters as admission
criteria, curriculum design, clinical preceptorships, role delineation, faculty training, and continuing medical education.

Both AAPA and APA relied at first on voluntary leadership, but effective functioning was thus dependent on the time availability of the elected officers. In the summer of 1973, Alfred M. Sadler, Jr. MD and Thomas E. Piemme, MD, Past President and President of APA, successfully sought and received sufficient private foundation funds to establish a joint national office in Washington, D.C. They recruited Donald W. Fisher, PhD, to serve as Executive Director of both organizations. Full time staff was now available to advance the interest of the PA movement and to serve as a resource for the states as they revised their medical practice statutes. Common management served to promote cohesion of interest between education and practice.

A National Conference of Convergent Interests

Between 1968 and 1972 Duke University hosted four invitational conferences to provide a forum for the exchange of experiences and ideas among existing and emerging programs. At the fourth of these gatherings in April 1972, Duke suggested that the time had come for national organizations to carry on what they had started. The leadership of AAPA and APAP began planning for a national conference to be held in April 1973. Since no funds were available, the PA program at Sheppard Air Force Base offered to host the meeting at its facilities in Wichita Falls, Texas, and the Air Force willingly advanced the necessary “seed money” until registration fees were received.

The conference was billed as the “First Annual Conference on New Health Practitioners” in the hope that there might be substantial participation by the growing number of nurse practitioners. The conference proved ultimately to be the first of the annual meetings of the AAPA.

While there were presentations on emerging legal issues and reports of early studies of PA utilization and cost effectiveness, the highlights of the meeting were the presentations by the NBME and the AMA. The first national certifying examination was only a few months away and the JRC-PA now had a year of experience with accreditation of
programs. Those who attended the meeting came away, reassured that the PA concept was healthy and would endure.

**Dependence vs. Independence and the Evolution of the Role of the Physician Assistant**

Although Hudson, Stead, Smith, and other pioneers of the PA concept initially envisioned the role of the PA primarily as a data gatherer, performing somewhat limited, but repetitive tasks (the common phrase among them vs. “extending the arms and legs of the physician”), it quickly became apparent that the PA could do much more. Given the prior experience of the students, most of whom had been military corpsmen, clinical evaluation and treatment of injuries were a natural fit. Add to that the skills of history-taking and physical examination, and the evolution into diagnosing, treating, operating and prescribing was natural and inevitable. Working under the supervision of physicians, a diligent PA can, over time, master much of the scope of practice of her or his mentors. Within a few years of the introduction of the concept, PAs were, in effect, practicing medicine.

Although both accreditation and certification were designed for the “assistant to the primary care physician,” it wasn’t long before some PAs gravitated to the specialties. PAs do what physicians do, and they will practice what physicians practice. Today PAs function in roles unimagined in the 1960s and 1970s.

Given that PAs do indeed practice medicine, there has been from time to time, an argument proffered by some that the PA might well function independently. Stead was forthright from the outset when he said that as long as PAs remain legally dependent on the physician, there is no limit to their scope of practice. If they were to move to practice independently, their scope of practice would be circumscribed and limited by the medical profession and state licensing boards.

The PA profession remains committed to the concept of the supervising physician-PA team. This is reflected in the American Academy of Physician Assistants’ (AAPA) description of the profession: “Physician assistants are health professionals licensed or, in the case of those employed by the federal government,
credentialed to practice medicine with physician supervision.” PAs are trained and educated similarly to physicians and therefore share similar diagnostic and therapeutic reasoning. Physician-PA practice can be described as delegated autonomy. Physicians delegate duties to PAs, and within those range of duties, PAs use autonomous decision-making for patient care (AAPA website).

**Physician’s Assistants or Physician Assistants**

Although early in the formation of the profession, PAs were referred to as “physician’s assistants,” the more commonly used and preferred way to refer currently to PAs is as “physician assistants.” There is a movement among some who are desirous of shifting the title to “physician associates” to better reflect the scope and nature of their work.

**Military Roots**

The current physician assistant profession has its roots in the military and stems from the healthcare needs of a changing US population.
following World War II. Yet physician assistants are not the first medical assistants in history. Feldshers, originally German military medical assistants (field surgeons), were introduced to Russian armies by Peter the Great in the 17th century. Feldshers continue to practice in modern Russia and are used to provide primary, preventive and maternity care services in rural areas.

In the 1770s, U.S. Congress passed a bill authorizing the navy to use hospital maters, modeled after the “loblolly boys” of the British Royal Navy, to assist physicians in the care of sailors. The name assigned to this position changed over the years to “surgeon’s steward,” “bayman,” and Hospital Corpsmen.

In 1891, Captain John Van Renssalaer Hoff, MC organized the first company of “medic” instruction for members of the Hospital Corps at Fort Riley, Kansas.

In 1898, with the Spanish-American War looming, Congress passed a bill authorizing establishment of the U.S. Navy Hospital Corps, signed into law by President William McKinley on June 17, 1898.

Beginning in 1930, former military corpsmen receive on-the-job training from the Federal Prison System to extend the services of prison physicians. This eventually leads to the establishment of a U.S. Public Health Service PA program in July 1968 at the Medical Center for Federal Prisoners in Springfield, MO. The program was the first to be federally sponsored, but was never accredited and was phased out in the 1970s when PA training became widely available elsewhere.

Generally considered the “father” of the physician assistant profession, Dr. Eugene Stead, Chairman of the Department of Medicine at Duke University for 20 years following World War II, was an early proponent of engaging the talent and skills of ex-military corpsmen to serve the civilian public… (Piemme, p. 17)

Feldshers and others (p. 12-onwards in Piemme)

The original training for physician assistants was modeled after fast-track physician training employed during World War II when battlefield care was emergently needed. Today, according to the American Association of Physician Assistants (AAPA), of the more
than 90,000 physician assistants currently practicing in the United States, more than 10,900 are military and veteran PAs. Of these, 41% work in primary care. A full 1.9% of PAs are veterans, active duty or retired military in the Reserves / National Guard. On average, these veterans each have 18 years clinical experience as a PA. Not surprisingly, the U.S. Department of Veterans Affairs is the largest employer of PAs in the country.

Today, fifty years after the birth of the physician assistant, the profession remains closely allied with its roots in both the military and in clinical medical practice. The PA role was developed by far-sighted physicians who envisioned a relationship in which an experienced and well trained colleague would collaborate in their practice. The PA concept has thrived for a half-century and has become a mainstay of efficient and effective healthcare delivery in the United States and beyond.

Image courtesy of American Association of Physician Assistants (AAPA).
Physician Assistants - The Present

Ever since those three former Navy corpsmen graduated from a new medical education program at Duke University in 1967, the physician assistant profession has grown and flourished. The PA concept was lauded early on and gained acceptance and backing federally as early as the 1970s as a creative solution to physician shortages. The medical community helped support the profession and spurred setting accreditation standards, establishing a national certification and standardized examination, and developing continuing medical education requirements. PAs today perform physical examinations, diagnose and treat illnesses, order and interpret lab tests, perform procedures, assist in surgery, provide patient education and counseling and make rounds in hospitals and nursing homes. All 50 states and the District of Columbia allow PAs to practice and prescribe medications, and PAs are currently providing care in US territories (AAPA). According to the National Commission on Certification of Physician Assistants, there are more than 90,000 nationally certified PAs.

Image courtesy of American Association of Physician Assistants (AAPA).
According to the 2012 Census of the American Academy of Physician Assistants, about one-third of PAs currently work in primary care (defined as family medicine, general internal medicine, general pediatrics and OB-GYN) and two-thirds work in specialties including emergency medicine, hospital medicine, general surgery, surgical subspecialties and internal medicine subspecialties. There are over 7,500 physician assistants who practice medicine in governmental and military settings. While limited in options, PAs can practice internationally and interest in global health utilizing physician assistants continues to expand.

Interest in the PA profession has grown dramatically, and entry into the profession is highly competitive. There are currently over 180 physician assistant programs in the US providing instruction in anatomy, physiology, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory science, behavioral science and medical ethics. Each year, approximately 6,000 students graduate from accredited PA programs in the United States, and PA programs have been successfully started in a number of international locations. Canada, the Netherlands, India and Saudi Arabia all have PA programs, and South Africa has developed a similar program in which program graduates are called “clinical associates.”

By design, the hallmarks of the PA profession today are its flexibility to meet the needs of the changing healthcare environment, its strong foundation in the medical model of education and its MD-PA team orientation.

**How are PAs educated and trained today?**

The PA educational program is modeled on the medical school curriculum, a combination of classroom and clinical instruction. The PA course of study is rigorous and intense. The average length of a PA education program is 27 months.

Admission to PA school is highly competitive. Applicants to PA programs must complete at least two years of college courses in basic science and behavioral science as prerequisites to PA school,
analogous to premedical studies required of medical students. The majority of PA programs have the following prerequisites: chemistry, physiology, anatomy, microbiology and biology. Additionally, most PA programs require or prefer that applicants have prior healthcare experience.

PA education includes instruction in core sciences: anatomy, physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory science, behavioral science and medical ethics.

PAs also complete more than 2,000 hours of clinical rotations, with an emphasis on primary care in ambulatory clinics, physician offices and acute or long-term care facilities. Rotations include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine and psychiatry.

Practicing PAs participate in lifelong learning. In order to maintain national certification, a PA must complete 100 hours of continuing medical education every two years.

There are currently more than 180 accredited PA programs in the United States. The vast majority award master’s degrees. PA education programs are represented by the Physician Assistant Education Association and accredited through the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).

The Physician Assistant Profession in Oregon

While the physician assistant profession had its formal start nationally with the graduation of the first class of students from Duke University in 1967, PAs were not recognized as health care providers in the State of Oregon until 1971 when the state legislature passed House Bill 1053. Early PA pioneers were challenged with introducing a new medical profession that was relatively unknown, but support from the medical community spurred interest in the PA as a creative solution to physician shortages in Oregon. Over time, administrative rules governing all medical practice in the state were to be adjusted to accommodate this new role. Legislative language allowing limited prescriptive authority to PAs was introduced in 1979 – today PAs have
prescribing authority for Schedule II-V drugs. From that first licensed PA in 1971, there are now more than 1,200 PAs practicing in Oregon hospitals, physician group and solo practices, community health centers and rural health clinics. About 37% of Oregon PAs provide primary care services in Family Medicine, General Internal Medicine, General Pediatrics and OB/GYN. Physician assistants are also utilized in Pediatric and Internal Medicine subspecialties, and nearly 40% are working in Surgical Subspecialties. The typical PA sees 51-60 patients per week, 20% of whom are Medicaid beneficiaries and 30.7% are Medicare beneficiaries. Physician Assistants are integrated into Oregon’s Coordinated Care Organizations as part of the health care team and are increasingly sought after in this era of healthcare transformation.

The Oregon Society of Physician Assistants

The first meeting of the fledgling ‘Physician Assistants Association’ was convened in April 1974 at the University of Oregon Medical School (now OHSU) by a small group of PA pioneers whose first action was to agree upon the name – Oregon Society of Physician Assistants. At the time of its inception there were only sixty six physician assistants licensed in Oregon, and they hailed from across the entire state. The organization was created to serve this new and growing profession and support efforts to clarify the role of the PA in medicine.

OSPA is one of 56 constituent chapters of the American Academy of Physician Assistants – the national professional society representing physician assistants. OSPA’s mission is to promote quality, cost effective, and accessible health care; to support the professional and personal development of physician assistants; and to advance the PA profession as well as the MD-PA team approach to health care. The success of the organization and that of PAs in Oregon is due to the hard work of the many active PA volunteers who willingly sacrifice their time and energy to enhance understanding of the PA role.
PA Pioneers in Oregon

Early physician assistants faced many challenges as the profession developed; the role was unknown or misunderstood, there were few regulatory statutes defining PA practice and processes for reimbursement for PA services had not yet been developed. Despite these difficulties, a cadre of PAs was instrumental in laying the foundation for the growth of the profession in Oregon. There are numerous examples of creative and dedicated Oregon PAs who had a hand in the success of the PAs who followed in their footsteps – too many, unfortunately, to include here. A few of the notable early Oregon PA Pioneers include Josiah Hill, Dave Jones and Dennis Bruneau, Sandra Ford, Barbara Coombs Lee and Dana Gray.

In 1971, Josiah Hill III was the second physician assistant to be licensed in the State of Oregon. Throughout his medical career he cared for the communities of North and Northeast Portland. As a board member of the Oregon Chapter of Physicians for Social Responsibility and community activist, he partnered with the Coalition of Black Men and pioneered a volunteer-based mobile blood lead testing clinic that ran for many years. Upon his death in 2000, the Josiah Hill III clinic was founded to provide ongoing care to underserved and in-need families in his honor, and a scholarship in his name was established at Pacific University.
After several years of trying to recruit a physician without success, Gilliam County employed PA pioneers Dave Jones and Dennis Bruneau in 1980 to provide medical care in the rural community of Condon – the first PAs to be allowed to practice remotely from their supervising physicians by the Oregon State Board of Medical Examiners. The experiment was so successful it went on to win awards, and the administrative rules by which physician assistants practice now include opportunities for PAs to deliver patient care in rural and underserved areas. The pair have received numerous honors including receiving the AAPA National Rural Physician Assistant award for 1988. Oregon Story: Country Doctors, Rural Medicine, an educational program developed by Oregon Public Broadcasting highlighted Jones and Bruneau in an exploration of the challenges faced by rural communities in attempting to address their health care needs.
Sandra Ford

Sandra Ford was instrumental in the establishment of the Fred Hampton Memorial People’s Clinic, a free clinic in North Portland operated by the Portland chapter of the Black Panthers in the late 1960s. By 1970 the clinic was seeing 25-50 patients each evening and had added a dental clinic. Ford developed an interest in medicine while working various roles in the clinic, and in 1977 she attended the University of Washington MEDEX PA program. As a physician assistant, Ford has spent much of her professional career focused on behavioral health issues, and in 1998, coauthored an article with David Pollock, MD on the role of the physician assistant in community mental health settings. Today with an accumulated 40 years of healthcare experience she continues to serve vulnerable populations as a physician assistant in a community mental health clinic in Portland.
Barbara Coombs Lee has worn many professional hats during her career. After initial training as a nurse, Coombs Lee embarked on a path to medical practice as a physician assistant, graduating in 1975 from the MEDEX program at the University of Washington. She held many leadership roles as a PA, including chairing the PA Committee for the Oregon Board of Medical Examiners, and broke new ground after being hired by Dr. Henry DeMots, Chief of Cardiology at the Portland Veterans Administration Hospital, where she became the first physician assistant nationally to perform coronary angiography. In addition to her interest in medicine, she cultivated an interest in law and decided to add a law degree to her list of credentials. Since graduation from Lewis & Clark Law School she has devoted her professional life to the rights and choices of the terminally ill. Co-author of the Oregon Death with Dignity Act, she is the president of Compassion and Choices - a nonprofit committed to helping people plan for death.
Dana Gray (left) learned about the PA concept while serving as an Army Medical Corpsman. As a PA he has been a longtime leader in a variety of professional organizations including the Oregon Society of Physician Assistants, the American Academy of Physician Assistants, the Association of Physician Assistants in Cardiovascular Surgery and he was a founding member of the PA History Society. After practicing in cardiovascular surgery for more than 30 years, Gray and his physician partner Jonathan G. Hill (right) received the AAPA Physician-PA Partnership Award in 2010. This honor recognizes a physician-PA team that exemplifies the unique relationship of trust, collegiality and mutual respect that is essential to the PA profession and allows for greater medical service to patients.

Dana Gray (L).
Image courtesy of Dana Gray.

Physician Assistant Education in Oregon

As the PA profession grew in Oregon, so did interest in training opportunities. Anyone wishing to become a physician assistant in the early days of the profession had to leave the state to do so, and students who did leave the state frequently did not return after graduation. The lack of educational opportunities in Oregon led to
legislative action resulting in the development of two PA programs – providing an increased likelihood that Oregon communities could be cared for by this new medical professional.

**Oregon Health & Science University**

The Physician Assistant Program at Oregon Health & Science University is the outcome of legislative activities of Oregon rural health constituencies and the Oregon Society of Physician Assistants (OSPA). In 1991, these groups lobbied for Senate Bill 607 which recognized “(1) that Oregon faces a shortage of primary care providers in rural areas, and (2) that PAs could play a role in addressing this problem.” The bill further mandated the Oregon Office of Rural Health to identify the requirements and opportunities for establishing an Oregon physician assistant program. The resulting feasibility study was submitted to the Legislative Emergency Board in June, 1992.

In 1993, the OSPA introduced legislation for “start-up” funding for a PA program in Oregon through Senate Bill 81, and ultimately Oregon Health & Science University was designated as the appropriate site for the program. An advisory committee from OHSU administration, the Office of Rural Health, the School of Medicine, OSPA, the School of Nursing Nurse Practitioner Program, the Primary Care Association, and the State Health Division (with contributions from Ruth Ballweg, PA-C, Director of the MEDEX Northwest Physician Assistant Program) worked toward successful establishment of the program and the hiring of the founding Director Ted Ruback MS, PA.

Since its inception in 1994, the program has become a free-standing division within the OHSU School of Medicine and has transitioned from a baccalaureate program to awarding a master’s degree. Since 2003, its first year of eligibility, the US News & World Report has consistently recognized the OHSU PA Program as one of the top ten PA programs in the country. Graduates have achieved a remarkable 99.1% first-time pass rate on the national certifying examination. From that initial graduating class of eleven in 1995, more than 450 OHSU PA graduates are now providing care for the communities of Oregon, the Pacific Northwest and beyond.
Pacific University welcomed their first class of 14 Physician Assistant students in 1997 to the Forest Grove campus. From that small beginning, the class has now grown with 44 clinicians due to graduate in 2014 with a Master of Science degree. The founding director of the PA school, Dr. Christine Legler, passed the baton on to Randy Randolph PA-C and the current Director of the school is Judy Ortiz, PA-C. The School of PA Studies is part of the College of Health Professions, along with other programs such as Pharmacy, Physical Therapy, Occupational Therapy, Healthcare Administration and Leadership, Professional Psychology, Athletic Training, Dental Hygiene, and Audiology. The school offers a Hawaii Outreach Program and has a long standing history of supporting veterans to become physician assistants, including a Veterans Outreach Program and a Bachelor’s Degree Completion option.

**Physician Assistants – The Future**

The future of the Physician Assistant profession appears bright indeed. While a relatively recent addition to the cast of healthcare providers, PAs have proven themselves to be adaptable, highly skilled and well trained in a medical model similar to that used to educate physicians. Because PA education is generalist in nature, PAs are not constrained to work in a single specialty area. This flexibility to provide services across the spectrum of medicine is a particularly appealing aspect of the PA role as it affords opportunities to be responsive to changing healthcare needs. The Bureau of Labor Statistics has consistently ranked the PA profession as one of the 30 fastest-growing occupations in the country with a projected 38% employment increase during the 2012-2022 timeframe. Forbes Magazine recently identified ‘Physician Assistant Studies’ as the best master’s degree for jobs, an important consideration in this time of rapid change and economic uncertainty.

In keeping with the exponential growth of the profession, the supply of clinically active PAs is estimated to grow to 93,099 in 2015, 111,004 in 2020, and 127,821 in 2025. Educational level, minority
representation, and the age of the PA workforce have all increased over time. Additionally the profession has included more women: in 1980, 64% of PAs were male, by 2007, over 66% of PAs were female.

PA training programs have, since their inception, been seen as “an efficient means of preparing clinicians who provide considerable benefit to society in return for a modest public investment” (Cawley, 2008), as well as a necessary strategy for providing primary care for diverse populations in urban and rural underserved areas. These trends appear to be poised to continue well into the future, partly because of recent changes in the American health care system.

The Patient Protection and Affordable Care Act (PPACA), passed by U.S. Congress then signed into law by President Obama on March 23, 2010, has the potential to make preventive and primary care more accessible to a larger number of Americans. To accomplish this,
however, many more primary care providers need to be trained and available to the workforce, well beyond the scope of the anticipated growth of physicians going into primary care. Other health care providers who could provide primary care, including but not limited to physician assistants and nurse practitioners (NPs), are seen as a key to helping provide this needed primary care in the future.

Even an increase in number of physician assistants may not be sufficient for this growth in primary care. According to the Agency for Healthcare Research and Quality (AHRQ), “the growth of physician assistants (PAs) in the U.S. medical workforce will not be sufficient to meet the future needs of primary care, especially given the predicted shortage of primary care physicians.” According to a 2012 AHRQ study, current number of PAs (72,000) will grow by almost 72 percent by 2025, but this growth will only provide 16% of the providers needed to address the projected primary care physician shortage. The need for primary care providers and other health care providers who can nimbly respond to our ever-changing health care system ensures that physician assistants will be an essential partner in medicine well into the future.
PAs have much to offer healthcare reform efforts, the goal of which is to provide care for all Americans while reducing healthcare costs through adequate preventive care. PAs help extend physician care and can easily adapt to any care model. Their education prepares them to work in teams, and they help to coordinate care and provide preventive services. Physician Assistants were recently recognized by Congress and the President as crucial to improving U.S. healthcare, an acknowledgement that would have been appreciated by Dr. Eugene Stead, the “father” of the PA profession - a physician who foresaw the potential for this profession. From those military medics who bravely volunteered to be a part of an experiment in creating a new type of medical provider in the 1960s, the physician assistant profession has grown to be an important member of the healthcare team, not only in the United States but globally as well.

If the past 50 years have proven anything, it is that the physician assistant profession is here to stay. PAs fill a unique and vital role in the team-based delivery of healthcare in America. Just as the need for access to quality healthcare in the US is only projected to grow well into the future, the PA profession - a profession designed by physicians - will be there to grow along with it, working as partners with physicians to meet the fundamental healthcare needs of our nation’s citizens.
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Physician Assistants: PArtners in Medicine Past, Present and Future

A collaboration of the OHSU Historical Collections & Archives and the OHSU School of Medicine Division of Physician Assistant Education