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Professor Phil Banfield
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Dear Professor Banfield

RE: PHYSICIAN ASSISTANTS

Thank you for your correspondence seeking advice on the current situation with respect to physician assistants in Australia.

The role of physician assistants and its utility in the context of the Australian health system has been previously explored. There have been two trials conducted, with the first being in South Australia from 2008 to 2009. This pilot involved six US-trained PAs working across three sites: Queen Elizabeth Hospital, Royal Adelaide Hospital, and Flinders Medical Centre. Following this, Queensland Health conducted a pilot trial in 2010, where five US-trained PAs were employed at four sites over 12 months.

The outcomes from these trials and research undertaken by the former Health Workforce Australia were considered by health ministers at the time and, despite their early enthusiasm, no further action was taken to develop the role in Australia.

The first physician assistant education program in Australia was offered by the University of Queensland (UQ), however this program ceased in 2011. James Cook University (JCU) in Queensland also developed its own physician assistant training program and this too recently ceased.

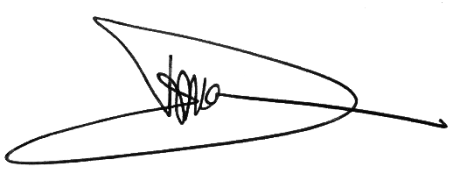
The reality is that Australia has a highly skilled health workforce with the role of each health profession continuing to evolve in response to the changing health care needs of the community. While there are an estimated 40 physician assistants in Australia, it is an orphaned workforce that has not been integrated into the Australian health system and this reflects the fact that there is no demonstrated need for physician assistants in the Australian context.

There is strong opposition to the role in Australia from a broad cross section of health professions including the medical and nursing professions. While the role is promoted as a solution to workforce shortages, the root cause of these shortages is the chronic failure to invest properly in the existing medical workforce and the broader health system. It is disappointing that policy makers ignore this and look instead to simplistic solutions that fragment care, deliver poorer health care outcomes and result in higher costs in the longer term. There is also longstanding concern that physician assistants will cannibalise roles and training opportunities that would normally be available to doctors in training.

Physician assistants are not currently a regulated health profession in Australia and clinical governance of the role falls to employers to manage through local policies and employment directives. These arrangements do not effectively regulate their scope of practice and feedback from our doctors in training, in particular, would suggest that the roles being offered to physician assistants in the public sector would be more suited to a resident medical officer.

I hope the above is of some assistance to you. We are seeing some very recent interest from Queensland Health in developing the physician assistant role in that state but opposition to this is significant for all of the reasons outlined in this letter.

Yours sincerely



Dr Danielle McMullen
President

22 February 2025

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AMERICAN MEDICAL ASSOCIATION

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March 13, 2025

Professor Phil Banfield
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Dear Professor Banfield:

On behalf of the physician and medical student members of the American Medical Association (AMA), thank you for contacting the AMA to request our perspective on the role of physician associates in the United States (U.S.). Of note, physician associates are licensed and commonly known as "physician assistants" in the U.S., therefore, this is the term I will use throughout this letter. The physician assistant profession began in the U.S. in the 1960s with the goal of supporting primary care physicians as trained assistants and working as part of a physician-led care team. This remains the prevailing model across the U.S. today. Physician assistants primarily practice in physician offices and hospitals alongside and under the direct supervision of a qualified physician. The importance of physician-led care is codified in state statutes and regulations with 45 states currently requiring physician supervision or collaboration of physician assistants. While the physician assistant profession was originally created to support primary care physicians, today, most physician assistants are currently practicing in non-primary care specialties.

The AMA is firmly committed to physician-led team-based care with each member of the team working together to provide the highest quality of care for patients. We believe that physicians are uniquely qualified to lead the health care team based on our well-proven pathway of education and training, including four years of medical school, three-to-seven years of residency training, and more than 12,000 hours of clinical training. By contrast, physician assistants are trained to practice as part of a physician-led team as their programs are just two years in length and require only 2,000 hours of training with no residency requirement. **As such, physician assistants have neither the didactic education nor clinical training to practice independently and are not a replacement for a physician**.

AMA policy supports physician-led team-based care and opposes the independent practice of physician assistants.

The AMA has extensive and long-standing policy supporting physician-led team-based care and opposing the independent practice of physician assistants. Fundamentally, the AMA believes that all health care professionals play an important role in delivering efficient, accurate, and cost-effective care to patients. We believe that each member of the team, including physician assistants, brings a different skill set based on their varied education and training and, without exception, that physicians are uniquely trained to lead the health care team. AMA Policy H-160.906 entitled, "Models / Guidelines for Medical Health Care Teams," provides guidelines for physician-led health care teams, defining "physician-led" in the context of team-based care

"the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills."

This policy also describes in detail key elements of a physician-led care team, including the different clinical roles and responsibilities of physicians and non-physician practitioners based on their education and training. In addition, the AMA Code of Medical Ethics 10.8 entitled, "Collaborative Care," speaks to physician-led care and emphasizes that physicians are uniquely situated to serve as clinical leaders of the care team stating, "by virtue of their thorough diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient." Code of Medical Ethics 10.8 also outlines the ethical responsibilities of physicians as leaders within health care teams.

The AMA also has extensive policy related specifically to physician assistants, including Policy H-35.989 entitled, "Physician Assistants," which among other provisions states that physician assistants shall only function under the direction and supervision of a duly qualified licensed physician and that our AMA opposes legislation or regulation that allows physician assistant independent practice. AMA Policy H-160.947 entitled, "Physician Assistants and Nurse Practitioners H-160.947," also specifies the role of the supervising physician and describes in detail the parameters for appropriate supervision. Finally, AMA Policy D-405.977 entitled, "Non-Physician Title Misappropriation," expresses AMA opposition to efforts by the American Academy of Physician Assistants to change the official title of the profession from "physician assistant" to "physician associate;" a relatively new issue in the U.S..

Patients support physician-led care.

In the U.S., patients have consistently expressed their preference for physician-led team-based care. Multiple surveys over the years have shown that patients want and expect physicians to lead and manage their health care. Specifically, in a recent AMA survey, 95 percent of U.S. voters agreed that physicians should be involved in their medical diagnoses and treatment decisions. Patients clearly want and expect the most highly trained health care professional to be involved in their health care and value the expertise and skill physicians bring as leaders to the health care team. Likewise, students graduating from physician assistant programs expect that they will work with a physician when providing care to patients. Data from the Physician Assistant Education Association indicate that 91 percent of physician assistant students nearing graduation described the collaborating physician relationship as "essential" or "very important."

Physician assistants practicing without physician involvement will increase overall health care costs.

There is strong evidence that a physician assistant, practicing without any physician involvement, results in worse patient outcomes while also increasing costs due to overprescribing and overutilization of diagnostic imaging and other services. A case in point is a study conducted by Hattiesburg Clinic (the Clinic), a leading Accountable Care Organization (ACO) in Mississippi. This study found that **allowing non-physicians, including physician assistants, to have their own primary care panel of patients led to higher costs, more referrals, higher emergency department use, and lower patient satisfaction than care provided by physicians.** Based on Medicare cost data, the Clinic found the Medicare ACO patients spend was nearly $43 higher per member per month for patients with a non-physician as their primary care provider compared to those with a physician.[1] These costs could have translated to an additional $10.3 million in spending annually for the Clinic. Adjusting for patient complexity, this

[1] Batson BN, Crosby SN, Fitzpatrick J. Targeting Value-Based Care with Physician-Led Care Teams. *Journal of the Mississippi State Medical Association.* Jan. 2022.

number jumped to over $119 in extra costs per member per month or $28.5 million in additional costs annually. Data from this study also found that non-physicians had higher rates of utilization, including visits to the emergency department and referrals to specialists. In addition, physicians scored higher in nine out of ten quality metrics and received higher patient satisfaction scores compared to non-physicians, including physician assistants. Based on the results of this study, the Clinic made some significant changes to their delivery of care model. Specifically, the Clinic continued to rely on and use non-physicians, including physician assistants, to provide patient care, but changed their model to ensure that they were working in close collaboration with physicians. The authors opined, "We believe very strongly that APPs [advanced practice providers] are a crucial part of the care team; however, based on a wealth of information and experiences with them functioning in collaborative relationships with physicians, we believe very strongly that nurse practitioners and physician assistants should not function independently."[2]

Multiple studies have found that physician assistants and other non-physicians order more diagnostic imaging in the emergency department compared to physicians.

Consistent with the Clinic's findings discussed in detail above, it is noteworthy that in a recent study in *JAMA Network Open,* the authors found that non-physicians, including physician assistants, "are associated with an increased likelihood of an emergency department visit involving imaging, and for emergency department visits with imaging, a greater number of imaging studies were performed per visit."[3] The presence of non-physicians in the emergency department was associated with 5.3 percent more imaging studies per emergency department visit, including CT, radiography, fluoroscopy, MRI, and ultrasound. Finally, the authors note their findings are consistent with other studies that found increased imaging by non-physicians in the outpatient setting and the emergency department.

Other studies have also found that physician assistants tend to prescribe more frequently compared to physicians.

In addition to the above, a 2020 study published in the *Journal of Internal Medicine* found that 8.4 percent of physician assistants prescribed opioids to more than 50 percent of their patients, compared to just 1.3 percent of physicians.[4] **The study further found that in states that allow independent prescribing, physician assistants and nurse practitioners were 20 times more likely to overprescribe opioids than those in prescription-restricted states.**[5] It is important to note that the study also found that from 2013 to 2017 almost every other medical specialty decreased opioid prescribing while nurse practitioners and physician assistants increased opioid prescribing.[6]

Physician assistants also tend to prescribe more antibiotics compared to physicians. A brief report by the Infectious Diseases Society of America examined nurse practitioner and physician assistant antibiotic prescribing, compared with physician-only visits for both overall visits and visits for acute respiratory tract infections (ARTIs) between 1998-2011.[7] **The study found that ambulatory visits involving nurse practitioners and physician assistants more frequently resulted in an antibiotic prescription compared with physician visits**. Similarly, with ARTI visits, nurse practitioners and physician assistants

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[2] *Id*.

[3] Christensen EW, Liu CM, Duszak R, Association of State Share of Nonphysician Practitioners with Diagnostic Imaging Ordering Among Emergency Department Visits for Medicare Beneficiaries, *JAMA Network Open*, Nov. 2022.

[4] Lozada MJ, Raji MA, Goodwin JS, Kuo YF. Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns. *Journal General Internal Medicine.* 2020; 35(9):2584-2592.

[5] *Id*.

[6] *Id.*

[7] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. *Open Forum Infectious Diseases*. 2016:1-4.

prescribed antibiotics 61 percent of the time while physicians prescribed antibiotics 54 percent of the time. The authors noted that their findings were consistent with several previous studies.[8]

Scope expansions do not improve access to primary care or underserved areas.

We often hear that expanding the scope of practice of physician assistants is necessary to increase access to care, particularly primary care and care for patients in rural and other underserved areas. This promise has not proven true despite several decades of promises by both physician assistants and advanced practice nurses. Simply put, expanding the scope of practice of physician assistants, by removing or weakening physician supervision or collaboration requirements, has not resulted in increased access to primary care nor access to care in rural areas. To explain, first, it is critical to consider workforce surveys that have consistently found that a growing number of physician assistants are practicing in non-primary care specialties, such as surgery, dermatology, and emergency medicine. In fact, in 2023 just 16.5 percent of physician assistants practiced in family medicine/general practice – a 2.1 percent decline from 2019. While the majority of physician assistants practice in non-primary care specialties, data show that only a small percentage of physician assistants receive any specialty specific postgraduate training and over half switch specialties at least once during their career. **This data confirms that physician assistants are increasingly choosing not to practice in primary care and that those providing care in specialties often have no formal training in that specialty, thus underscoring the importance of physician-led care.**

Second, decades of research have also found no evidence that increasing the scope of practice of physician assistants improves access to care in rural areas. Rather, the research has unequivocally shown that physician assistants tend to practice in the same areas of the state as physicians. This is true irrespective of state scope of practice laws. Moreover, the AMA is deeply concerned with the notion that patients in rural and underserved areas, often a vulnerable and medically complex population, should settle for care from a health care provider with a fraction of the education and clinical training of physicians. All patients, regardless of zip code, deserve care led by a physician.

Current state legislative landscape.

The AMA has long valued the commitment of physician assistants to the team-based model of care. The importance of physician-led care is codified in state statutes and regulations with 45 states currently requiring physician supervision or collaboration of physician assistants. Typically, state laws or regulations specify that the supervisory or collaborative practice arrangements must be specified in a written agreement that is signed by all parties and shared with the state medical board. Over the years, physician assistants have sought expansions to their scope of practice, including removing or weakening physician supervision or collaboration requirements. Despite these efforts, state lawmakers have resoundingly rejected these scope expansion proposals. The AMA is proud to work alongside state medical associations across the country on behalf of physicians and patients in defending the practice of medicine and supporting physician-led care to maintain the highest quality of care for patients. Our commitment to this collaboration is on-going. We are relentless in our advocacy – demanding that every patient, regardless of zip code, deserves to be cared for by a physician-led health care team.

[8] Grijalva CG, Nuorti JP, Griffin MR. Antibiotic prescription rates for acute respiratory tract infections in US ambulatory settings. *JAMA* 2009; 302:758–66.

We hope this information is helpful to the British Medical Association and the review team as you consider the physician associate role in the United Kingdom. If you have any questions or would like additional information, please contact Kimberly Horvath, JD, Senior Attorney, Advocacy Resource Center, at kimberly.horvath@ama-assn.org.

Sincerely,

Bruce A. Scott, MD

cc: Kimberly Horvath, JD
Elizabeth LaRocca, JD