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# Medical assistants

## A primary care workforce solution?

### Background

A new medical assistant training program has been developed as an innovative solution to the workforce pressures facing general practice in Australia.

### Objective

This article describes the development and implementation of the Australian medical assistant role and training program, and discusses key lessons learned in the 4 years after the first medical assistants were trained.

### Discussion

Medical assistants are trained to carry out delegated administrative and clinical assisting duties specific to the ambulatory care environment. Lessons learned thus far from the introduction of this national qualification include the need to consult widely within the health care profession in the development of new roles, the imperative to bring together health and education sector expertise, the importance of flexible course delivery and the need for clearer role and boundaries definitions. The experience from the program implementation described in this article may help inform further primary care workforce development.

■ **Australia's health workforce shortage<sup>1,2</sup> is giving rise to a range of innovative solutions. While increased responsibilities<sup>3</sup> have been proposed for existing health professionals (eg. practice nurses),<sup>4</sup> these are constrained by the existing workforce availability.<sup>5</sup> New roles, such as physician assistants<sup>6</sup> and nurse practitioners<sup>7</sup> have received mixed reactions<sup>8,9</sup> from some sectors, but are the subject of increasing interest.<sup>10</sup>**

The medical assistant (MA) is a common role overseas, described by Bodenheimer as 'ubiquitous' and, together with the clinician, making up the 'day-to-day working dyad in virtually all primary care practices'.<sup>11</sup>

The MA role, described in *Table 1*, was introduced into general practice in Brisbane, Queensland, in 2005.

### Development of the MA role in Australia

#### Identifying the need

In 2003, GPpartners, a division of general practice in Queensland, recognised a gap in training for general practice staff based on feedback received by practice liaison officers who visited the division's 220 practices on a routine basis. In their experience, general practitioners reported being overwhelmed by patient demand, bogged down in 'red tape' and unable to recruit GPs or nurses in sufficient numbers. Practice principals and practice managers complained of the time consuming difficulties of training newly employed staff for the general practice environment. Practice nurses reported the desire to participate in higher level patient services, such as nurse led clinics and home health assessments, but were unable to find time due to the constant burden of lower level tasks.

A survey of member practices also showed a number of practices using staff not formally trained to perform clinical duties (*Table 2*).

#### Defining the role

A series of focus groups was held with participants from 37 practices including 42 GPs and practice managers. Questions were put to the participants to test the acceptability of a role modelled on the European and USA MA roles.<sup>12,13</sup> Participants were asked to identify

what duties they would be willing to delegate to a person with such training (Table 3). This process proved to be essential in gaining clinician buy in, and ensuring the resultant role was highly relevant to the needs of the local general practice sector.

An exhaustive search of state and federal legislation was then conducted and meetings held with several medical indemnity insurers to refine the list of duties derived from the focus groups. These results formed the basis of the course content.

Widespread consultation with medical, nursing and other general practice related groups was undertaken in an attempt to dispel concerns of role substitution.

### The course development process

Discussions with members of the Australian higher education and the vocational education and training sectors ultimately resulted in a key decision to develop the course within the Australian quality training framework. This reflected the introductory level at which the

qualification was pitched, and likely wage expectations, while still allowing the possibility of later progression from a medical assisting qualification on to higher education awards.

A Course Development Advisory Committee (Table 4) oversaw the development of the original course content, which in 2004 received accreditation in Queensland from the Training and Employment Recognition Council as the Diploma of Medical Assisting.

In 2005, Australia's Community Services and Health Industry Skills Council formed an industry reference group (Table 5) to oversee the incorporation of the MA course into the national health training package. After contentious deliberations, the revised Certificate IV in Medical Practice Assisting was included in the national health training package. The qualification was endorsed by all Australian states and territories in 2007, paving the way for future rollout of the MA course across Australia.

### The course implementation

The original course was delivered through TAFE in a 1 year full time or 2 year part time course in 2005 and 2006 in Brisbane, at a cost of \$7450 per student. The course consisted of 484 total hours of face-to-face classes and 225 hours of supervised practice placements to assess administrative and clinical skills in a working general practice environment. The cost and time commitment required for the face-to-face classes appeared prohibitive as initial interest did not translate to enrolment, especially for the large numbers of interested candidates already working in general practices.

The 2005 student intake resulted in five graduates and the 2006 intake in eight graduates. The majority of graduates quickly found employment in general practices, with the exception of those for whom English is a second language. Potential employers judged communication to be a key job requirement, especially for the reception elements of the role, and were reluctant to employ graduates with perceived deficiencies in their English language skills.

The average starting pay rate of graduates with no previous general practice experience was \$17/hour, while those with health related experience started on pay rates of around \$20/hour.

Experience to date indicates there are a number of interesting factors that influence whether practices employ an MA or not. These factors are the subject of research currently being conducted by the authors, however, the following case studies provide illustrative examples.

### Employment outcomes

Three of the program's students were already employed in general practices that had encouraged their employees to attend the MA course. One of these practices intended to utilise their graduate in a dual front desk and treatment room role, however, a follow up visit revealed the graduate had settled into a predominantly treatment room

Table 1. What is a medical assistant?

- MAs are trained specifically for the ambulatory care environment
- MAs perform delegated tasks at the direction of the supervising practitioner
- MAs provide basic clinical and administrative assistance in medical practice settings including:
  - applying wound dressings
  - appointment scheduling
  - assisting with minor procedures
  - billing
  - collecting and handling specimens
  - inventory/stock control
  - measuring blood glucose
  - measuring BP, pulse, temperature, respirations
  - measuring height, weight, visual acuity
  - performing ear irrigation, ECGs, spirometry
  - performing urinalysis and pregnancy testing
  - performing venepuncture
  - recalls and reminders
  - removing plasters
  - removing sutures
  - sterilising instruments
  - testing hearing and colour vision

Table 2. Who assists with what duties?

GPpartners 2003 survey results from 152 respondent practices				
Duty	Practices without a nurse		Practices with a nurse	
	Receptionist	Practice manager	Receptionist	Practice manager
ECG	19%	17%	11%	9%
Spirometry	11%	10%	11%	9%
Wound care	7%	5%	3%	6%
Immunisations	2%	2%	0%	6%
Ear syringing	2%	1%	0%	5%

Table 3. Potential duties and roles of medical assistants

**GPpartners 2003–2004 focus group results involving respondents from 37 practices**

- A list of 137 potential duties was voted on by 37 respondents
- 126 of 137 duties received a 'yes' vote from over 70% of respondents, categorised as follows:
  - 35 of 36 administration duties
  - six of 6 emergency care duties
  - 24 of 30 general duties
  - 12 of 13 immunisation duties
  - two of 4 child health duties
  - four of 4 recall of abnormal results duties
  - four of 4 wellness and health promotion duties
  - eight of 9 diabetes annual cycle of care duties
  - five of 5 Asthma 3+ visit plan duties
  - six of 6 accreditation duties
  - 10 of 10 infection control duties
  - six of 6 health assessments duties
  - four of 4 care planning duties
- Of the remaining 11 duties, results were as follows:
 

	Yes	No
– perform basic accounting functions (eg. including PAYE, BAS)	59%	41%
– perform phlebotomy	49%	51%
– undertake ear syringing	41%	59%
– draw up and administer injections	49%	51%
– undertake musculoskeletal plastering; fit splints	38%	62%
– collect throat swabs	68%	32%
– perform basic laboratory tests on collected specimens	57%	43%
– administer vaccines	51%	49%
– undertake primary developmental checks	65%	35%
– provide feeding advice (child health)	54%	46%
– undertake diabetic foot assessments	43%	57%

Table 4. Membership of the medical assisting course development advisory committee

- GPpartners
- The Royal Australian College of General Practitioners
- Australian Medical Association
- Australian General Practice Network
- Other GPs

Table 5. Membership of the medical assisting industry reference group

- GPpartners
- The Royal Australian College of General Practitioners
- Australian College of Rural and Remote Medicine
- Australian Medical Association
- Australian General Practice Network
- Royal College of Nursing Australia
- Australian Nursing Federation
- Australian Nursing and Midwifery Council
- Department of Defence
- Southbank Institute of TAFE
- Health Services Union of Australia

role which was working well for the practice. The practice reported the demand for the MA's skills in the treatment room was too high to be able to spare her for reception duties.

Seven practices have achieved a dual reception/treatment room role for their MAs. In four cases, the MA 'floats' to where the highest demand is throughout the day, while in the other three, the MA is assigned to the treatment room on certain days and the front desk on other days. This role flexibility is frequently cited by practices as an attractive aspect of medical assisting.

One practice employed a MA graduate without realising her training and skills. She was employed for a receptionist position, but explained the breadth of her skills to her employer soon after commencement of the job. The practice manager reported initial resistance to allowing a non-nurse to perform clinical tasks and therefore set up a rigorous assessment process whereby the MA was required to perform each clinical task in front of the practice principal and the practice's two experienced nurses. Based on her performance, the MA was given a role in the treatment room, releasing the practice's nurses to perform home health assessments and other tasks. The nurses had been wanting to focus more on health assessments

but had been unable due to their heavy treatment room workload.

All practices reported the importance of ensuring all members of their team, including patients, understood the role of the MA and the boundaries of that role, to ensure appropriate and best utilisation of the MAs' skills.

## Summary of lessons learned

The introduction of the MA qualification has taught valuable lessons in developing and implementing a new training program, as well as introducing a new role into a highly structured workplace. Key lessons have included:

- the need to consult widely within the health care profession in the development of new roles to gain clinician buy in, to ensure the relevance of the new role and to dispel concerns about role substitution

- the imperative to bring together health and education sector expertise in designing the training programs to support new worker roles
- the need for flexible course delivery, such as self paced and online delivery, is critical to provide accessibility for students, including those already working in general practice who cannot take time away from work for full time face-to-face study
- the need for consumers and all members of the general practice team to be educated regarding the boundaries of the MA role. This ensures teams function appropriately, the MA's skills are utilised effectively and the MA role adheres to legislative requirements, quality and safety standards.

## Conclusion

Although the MA role is common overseas,<sup>13–15</sup> it is a new and unknown qualification in Australia. For effective introduction of new roles, there is a need for those involved with redesign of the health workforce to draw together expertise from both the health and education industries. Traditional models of training must give way to innovative approaches, such as online learning, in the same way that traditional workforce models must change in order to meet the healthcare needs of our community.

This program provides a model for training and employing MAs within Australian general practice. Further research is needed to evaluate the optimal place of the MA role in Australian primary care and to determine its impact on the effectiveness and efficiency of general practice.

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