Medical assistants (MAs) have become a ubiquitous lot; it has become difficult to enter the health care system without some contact with an MA. As a group, they are relative newcomers to the health care scene, arriving in force with the advent of diagnosis-related groups in the 1980s. They tend to be much more diverse in gender, age, culture, educational background, and ethnicity than the typical nursing staff: 40% to 50% of nursing assistants identify themselves as nonwhite racial/ethnic minorities (General Accounting Office, 2001).

While this diversity can clearly be an asset as the ethnic composition of the United States changes, it is the other manner in which they are diverse that is problematic: their titles and their training. The term “medical assistant” can encompass such roles as nursing assistants, nursing aides, patient care assistants, home health aides, medication aides, or other unlicensed assistive personnel (UAP) and all can be with or without certification. There is commonly a wide range in the training required to fill these roles, depending on the particular work environment (Smith, 2004) and dependent on the state in which they work.

MAs fulfill important roles in today’s health care industry; they are often the initial point contact that a patient has when entering an outpatient clinic, and are fundamental to the daily routine in nursing homes and assisted-care facilities. There is no standard established for educating MAs, and many MAs receive training specific to a particular role after they have been hired (see Table 1). The previous 10 to 15 years have seen their role responsibilities increase dramatically, under a global “delegation” of duties that were traditionally inherent in the nursing role. Hospitals have included fingerstick blood glucose monitoring, oral suctioning, sterile dressing changes, maintaining tube feedings, urinary catheter insertion and removal, and phlebotomy among their job description (Cady, 2001; Smith, 2004). Long-term care facilities may include oral and rectal medication administration, and wound care or dressing administration (Smith, 2004) (see Table 2).

Many of these tasks were assigned to MA staff due to the shortage of RN staff. The intention was that by removing some of the less-complex tasks from RNs, nursing staff would be able to concentrate on more complex nursing tasks and the overall quality of care could be improved. This working relationship between RNs and MAs has taken a variety of forms over the years, from a partnership model to a nonpartnered model to an integrated model. The reality and success of these arrangements has been poorly examined in the literature, and has shown largely ambivalent outcomes with questionable cost savings (Lookinland, Tiedeman, & Crosson, 2005). This is at least in part because the term “nurse” has been used to describe any employee caring for patients.

In this era of continued pressures for cost containment, the drive to provide quality care, and staffing shortages at all levels, are MAs positioned to become “the future nurses?”

Role Confusion
MAs can and do fill a wide variety of roles. This can be a “generalist” role in a private practice that encompasses clerical, clinical, and administrative duties. In a hospital, MAs may have more specialized roles such as specimen collection, equipment sterilization, suture removal, or dressing changes. Permissible clinical duties will vary based on the individual laws of the state in which they are employed.

These tasks are legally limited by the basic tenets of delegation and limited by the nursing and/or medical boards of the particular state (depending on whom is assigning the delegated tasks). According to the American Nurses Association (ANA), delegation must be based on both the state’s nurse practice act and the individual skills of the person to whom a task is being delegated (ANA, 1992). But it is the environment in which there is no RN that the most expansive delegation may occur. In some states MAs can perform strep tests, venipuncture, notify patients of lab results,
engage in telephone followup after clinic visits, or administer injections (Tache & Chapman, 2005). With protocols in place and after a period of direct supervision, MAs can and do perform many traditional nursing tasks. But if the task falls within the scope of a professional license (MD, DDS, NP, PA, RN, or other) the MA cannot perform that task. If a task is not specific to a license, and the MA has been appropriately trained, the task can be assigned to the MA.

The danger comes in the temptation to overdelegate, or to inappropriately delegate, to MAs. There is a significant cost savings in employing MAs rather than RNs; the most recent data (from 2002) showed that MA salary ranged from $21,620 to $24,260 depending on the specific work environment (U.S. Department of Labor, 2005). A physician practice or health care facility can hire an individual MA and tailor his/her training to suit the specific needs of the environment very cost effectively. However, few studies are available that comment on the effects of MAs on long-term costs to a facility, or the administrative expenses and costs of training MAs (Lookinland et al., 2005).

Culture Shock

This sometimes indistinct nature and apparent overlap of the roles of the RN and the MA can create a hostile working environment for both parties, and this has been aggravated further by the continued restructuring that has occurred in the U.S. health care system. The scope of both the RN and MA has continued to evolve under the pressures to provide superior customer service to patients and other members of the health care team alike.

Potter and Grant (2004) reported that MAs/UAPs felt it was necessary to adopt an attitude of opposition, particularly if they had been assigned to more than one RN, or if they were repetitively questioned about their work. RNs reported that they often have concerns over the variations in MA training and background, and so are hesitant to delegate, even when their job requires it. Often this impression is fostered by the work design in a particular environment, where a single MA may need to report to two or more RNs. Nurses have also reported increased job dissatisfaction when assigned to work with MAs (Seago, 2000), commenting that they felt their workload actually increased due to the need to “double check” the work of MAs. If the RN (or any provider) and MA cannot partner effectively, there can be no insight into the needs of a particular patient group or provider and the efficiency of care suffers.

There are reports of positive working relationships. When assigned in a collaborative arrangement that is one-to-one, both MAs and nurses report high satisfaction (Potter & Grant, 2004). This type of arrangement affords the pair the luxury of access to one another and fosters easy communication, which in turn creates an environment of better patient care and increased patient satisfaction. Working as a team by attending shift report, rounding on patients, and sharing a plan of care for patients can help when prioritizing care needs and increase the RN’s efficiency when completing complex nursing tasks.

Seago (2000) reported that the best determinant of thinking and behavior styles was position: RN or MA/UAP. While the MAs/UAPs demonstrated an oppositional and dependent thinking style, they also scored as high in the humanistic-helpful domain as RNs. This indicates that there is a similar motivation inherent in the two roles, and that despite racial, ethnic, and educational differences, both groups are working toward the same goal. The challenge becomes creating a work environment that capitalizes on the potential and skills of both parties in a manner that is safe and cost effective, while affirming the inherent diversity of a mixture of caregivers.

To date, there is insufficient published data to recommend one specific method of care delivery that employs RN and MAs/UAPs (Lookinland et al., 2005). But it seems clear that when an RN and MA are partnered in a way that fosters both the completion of complex nursing tasks and allows the MA to observe clinical decision making, the quality and timeliness of patient care will increase.

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### Table 1. Medical Assistant Summary

- No standard training – Training varies from facility to facility, and state to state
- Widely varying roles
- Can follow clinical protocols
- Cannot make independent judgments
- Only 15% of MAs obtain national or state certification
- Do not have independent license: employer becomes the de facto controlling body

### Table 2. Common Medical Assistant Tasks

#### Administrative
- Answering the telephone
- Filing charts
- Transcription of dictation
- Scheduling appointments

#### Clinical
- Assisting with/chaperoning examinations
- Maintaining inventory
- Collecting specimens
- Removing sutures
- Preparing medications as directed by clinician

#### Advanced Clinical Duties
- Educate patients about procedures
- Venipuncture
- Develop policy and procedure manuals
- Perform ECGs
Medical assistants are invested in the successful and compassionate care of patients in diverse environments. Medical assistants must be offered opportunities to be challenged in their role (as does any caregiver) and to feel their educational needs are supported. This creates satisfied and motivated staff, which in turn aids retention and helps to avoid additional administrative burdens in training new staff.

Conclusions

Medical assistants are poised to become one of the fastest growing occupations during the 2002-2012 period (U.S. Department of Labor, 2005), and declining Medicare and Medicaid payments all but guarantee the increasing need for this role. It is an occupation that is especially suited to entry as a second career, as job prospects are solid with little individual investment in training. MAs are currently employed to perform routine administrative and clinical tasks that are vital to the efficiency and success of the offices of physicians, podiatrists, chiropractors, and other health practitioners. They also have vital roles in the day-to-day functioning of hospitals and long-term care facilities, and can sometimes be under-recognized for their contributions.

MAs are invested in the successful and compassionate care of patients in diverse environments. It is essential to remember that good intentions are not a substitute for the judgment, skill, and knowledge that is inherent in a licensed professional role when determining the roles of individual staff members. While there are many basic duties that MAs can perform in these varied environments, they can be most beneficial to a health care team as a whole when in a setting that enables them to work alongside a professional who clearly defines expectations and offers support.

The health care industry will continue to seek cost-effective ways to provide quality care to its patients as a response to managed care and as competition for reimbursement continues, while the shortage of caregivers at all levels continues. Medical assistants will continue to fill multiple roles within the health care industry, and the industry must ensure that these individuals are well-trained and appropriately supervised in order to avoid adverse events. But as the complexity of patients (particularly inpatients) continues to increase, it becomes clear that the only “future nurse” will remain the RN.

References


