Annals of Health Law

Volume 24
Issue 1 *Winter 2015*

Article 4

2015

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I. INTRODUCTION

For more than a century, controversy has surrounded health professionals' legal authority to practice.[1] In the late nineteenth and early twentieth centuries, states passed licensure laws to regulate physicians[2] and protect the public against quackery, commercial exploitation, deception, and professional incompetence.[3] These laws enforced standards for physicians to enter into and continue practice in the medical profession.[4] As a result, state medical practice acts developed ethical and educational requirements for physicians relating to personal character, scientific education, and practical training or experience.[5] The enactment of the Medical Practice Act of 1870 made medical licensure a function of the states.[6] The unanimous decision of the Supreme Court in *Dent vs. West Virginia* in 1889, in favor of the people of West Virginia, solidified the concept that states have the obligation to protect residents within their borders by regulating medical practice.[7]

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1. CARL F. AMERIGER, STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION 13 (Johns Hopkins Univ. Press 1999).

2. RODERICK S. HOOKER ET AL., PHYSICIAN ASSISTANTS: POLICY AND PRACTICE 409 (F.A. Davis Co. 3d ed. 2010).

3. *See* ROSEMARY STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST 32 (Yale Univ. Press 1972) (stating that, ". . . standards of education and practice were uneven . . ." and that ". . . there seemed to be a glut of doctors . . ."). *See also* Dent v. West Virginia, 129 U.S. 114, 122-23 (1889). *See also* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 130-132 (1982).

4. AMERIGER, *supra* note 1, at 13.

5. *Id.*

6. STEVENS, *supra* note 3, at 32.

7. *See* Dent, 129 U.S. at 122-23. The Supreme Court decided *Dent vs. West Virginia* in 1889. Frank Dent, a graduate of a school specializing in an alternate medicine known as "eclectic medicine," was practicing as a doctor of medicine in Newburg, West Virginia. The state found that Dent did not have a license to practice allopathic medicine, and indeed was not eligible for licensure as a physician. Dent was found guilty of practicing medicine without a license and fined $50. Dent appealed the state's decision, holding that the state was interfering with his "vested right in relation to the practice of medicine." The Supreme Court

Laws addressing the professional conduct of health professionals are evolutionary, and their historical roots have evolved in the United States over the past 140 years.[8] Significantly, the evolution of medical practice regulation broadened healthcare professional scopes of practice to include medical tasks previously restricted to physicians.[9]

In 1965, Duke University introduced physician assistants ("PAs") as a strategy to help over-extended physicians provide more services.[10] By 1974, thirty-seven states had passed legislation to authorize practice by these new practitioners.[11] Within four decades, a series of laws developed to govern the PA practice, including a network of statutes and regulations in the states, the District of Columbia, the United States Territories, and federal systems.[12]

In general, states are far from achieving uniformity in their laws, and PA legislation is no exception.[13] In less than fifty years, PA regulation originated through considerable legal activism, largely on the part of state and national PA organizations. This involved considerations of appropriate medical scope of practice, concern for public safety, and assurance of professional conduct.[14]

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ruled in favor of West Virginia, holding that the state had the authority and responsibility to restrict medical practice to those who are licensed "in the exercise of its power to provide for the general welfare of its people."

8. AMERIGER, *supra* note 1, at 13.

9. Barbara J. Safriet, *Closing the Gap Between Can and May in Healthcare Providers' Scope of Practice: A Primer for Policymakers*, 19 YALE J. ON REG. 301, 308 (2002). Prior to 1965, the only persons who could legally perform the acts of medical diagnosis and treatment were physicians. With the creation of PAs and NPs and their recognition in law, the legal notion that these tasks could be delegated to others became accepted and established in law.

10. Eugene A. Stead, Jr., *Conserving Costly Talents—Providing Physicians' New Assistants*, 198 J. AM. MED. ASS'N 1108, 1108-09 (1966).

11. Roger M. Barkin, *Directions for Statutory Change: The Physician Extender*, 64 AM. J. PUB. HEALTH 1132, 1134 (1974).

12. *See* James F. Cawley et al., *Origins of the Physician Assistant Movement in the United States*, 25 J. AM. ACAD. PHYSICIAN ASSISTANTS 36, 36-42 (2012) (discussing generally the forty year period during which there were laws passed in every state that permitted PAs to practice with physician supervision as well as acts authorizing prescribing of medications. All fifty states, the District of Columbia, and all U.S. territories, with the exception of Puerto Rico, authorize licensed PAs to practice medicine in teams with physicians, engage in a wide range of medical diagnostic and treatment activities, prescribe medication, and be reimbursed for their services).

13. AM. ACAD. OF PHYSICIAN ASSISTANTS, PHYSICIAN ASSISTANTS STATE LAWS AND REGULATIONS tbl.1 (14TH EDITION 2014) (illustrating the variation in laws and regulations from state to state).

14. *See* Nicole Gara & Ann Davis, *The Political Process*, *in* PHYSICIAN ASSISTANT: A GUIDE TO CLINICAL PRACTICE 80, 551-65 (Ballweg Thomas Moore et al. eds., 5th Elsevier Science 3d ed. 2013) (discussing the history and evolution of physician assistant laws and regulations since the inception of the profession).

This article examines the PA profession as a workforce innovation, and the policies and laws that impact PA scope of practice in an evolving healthcare system. Part II examines the innovations that influenced the creation of the profession, the adoption of state legislation, and the legal concepts used to frame legislation and policy. Part III describes the unique determinants of PA scope of practice and how these have evolved over time. Part IV analyzes PA scope of practice in primary, specialty, and subspecialty care, and examines the quality of care and range of services provided by PAs. Part V describes the scope of practice for PAs in a changing healthcare system and the determinants of change. Finally, Part VI predicts the future of PA scope of practice and the role the PA-physician team model will play in the evolution of healthcare.

II. INNOVATION MEETS LAW

The establishment of the PA profession in the 1960s brought about a voluntary sharing of privileges from one medical professional to another.[15] This decade also saw the creation of the nurse practitioner ("NP") and the revitalization of the role of the nurse midwife.[16] This represents a major transformation in American medical practice.[17] The PA movement in the United States resulted from a convergence of circumstances: increased specialization of doctors, the demise of the general practitioner, advancing technology, returning veterans with medical training, the war on poverty and other federal policies, and charismatic leaders who understood the processes of education and clinical training.[18] The public accepted the PA concept because doctors approved it and members of the public found that PAs improved access to care in underserved and rural areas.[19] Many doctors seemed comfortable with the need for the new profession and the American Medical Association ("AMA") offered its stamp of approval.[20] The fledg-

15. *See* Cawley et al., *supra* note 12, at 36-42.

16. Natalie Holt, *"Confusion's Masterpiece": The Development of The Physician Assistant Profession*, 72 BULL. HIST. MED. 246, 246-78 (1998).

17. *See* Cawley et al., *supra* note 12, at 36-42; *see also* W. Kissem, *Physician's Assistant and Nurse Practitioner Laws: A Study of Health Law Reform*, 24 U. KAN. L. REV. 1 (1975) (discussing the notion that PAs were authorized to perform the tasks of medicine).

18. *See* ALFRED M. SADLER ET AL., THE PHYSICIAN'S ASSISTANT: TODAY AND TOMORROW 9-18 (Yale Univ. School of Med. 2d ed. 1975). *See also* Roderick S. Hooker et al., *The Changing Physician Assistant Profession: A Gender Shift*, 26 J. AM. ACAD. PHYSICIAN ASSISTANTS 36, 36-37 (2013). *See also* W. Spitzer, *The Nurse Practitioner: Slow Death of a Good Idea*, 310 NEW ENG. J. MED. 1049, 1049-1051 (1984).

19. GARA & DAVIS ET AL., *supra* note 14. *See also* Martha Ballenger & E. Harvey Estes, *Licensure or Responsible Delegation?,* 284 NEW ENG. J. MED. 331, 331-34 (1971). *See generally* GERALDINE SABOL ET AL., ASPEN SYSTEMS CORPORATION, PHYSICIAN'S ASSISTANTS LEGAL REGULATORY SURVEY (Aspen Systems Corp. 1972).

20. Thomas C. Points, *Guidelines for Development of New Health Occupations*, 213 J.

ling PA profession took on tasks from the once sovereign domain of medicine.[21] The empowerment of PAs was facilitated, in part, by relative animosity between organized medicine and organized nursing.[22] The failure of these two powerful professions to collaborate to solve the problem of access to health care in the post-WWII decades advanced the concept of the PA.[23] Those who pioneered the profession were successful in certain strategies they employed, including initially utilizing veterans, not taking other professionals out of their roles in the healthcare workforce, and creating a practice framework that allowed PAs to function in concert with physicians rather than in competition with them.[24] This construct marks the major difference between PAs and NPs who seek a more independent stance in practice from physicians.[25]

In 1965, Dr. Eugene A. Stead, Jr., then former Chair of the Department of Medicine, founded Duke University's Physician Assistant Program.[26] The Duke program was the first in the country to train this new professional group.[27] However, the only legal framework that existed to authorize PA practice upon graduating from the program was a 1966 opinion from the Attorney General of North Carolina, which provided that the performance of delegated, physician-supervised activities by a PA did not violate state law.[28] Although this opinion facilitated the utilization of the profession in North Carolina, it was advisory in nature and had no legal authority in other

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AM. MED. ASS'N 1169-1171 (1970) (discussing the work of the AMA's Council on Health Manpower and supporting the utilization of PAs, as well as the development of guidelines for the establishment of educational and training criteria for new health professions, including PAs).

21. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 223 (Basic Books 1982) (discussing the assumption by persons who are not physicians (CRNAs, CNMs, others) performing medical tasks).

22. Cawley et al., *supra* note 12, at 42.

23. Holt, *supra* note 16, at 248-53.

24. *Id.*

25. *See* John K. Iglehart, *Expanding the Role of Advanced Nurse Practitioners — Risks and Rewards*, 368 NEW ENG. J. MED. 1935, 1935 (2013) (discussing how PAs, by law, work with physicians under their legal authorization and how this differs from the legal basis of NP practice, which does not always require physician supervision).

26. Eugene A. Stead, Jr., *Conserving Costly Talents—Providing Physicians' New Assistants*, 198 J. AM. MED. ASS'N 1108, 1108-09 (1966); *Physician Assistant Program,* DUKE UNIV. MED. CENTER, http://paprogram.mc.duke.edu/PA-Program/ (last visited Nov. 21, 2014) (asserting that Dr. Stead began the Duke PA program and was the chair of the department of medicine at the time cited).

27. Reginald D. Carter & Justine Strand, *Physician Assistants: A Young Profession Celebrates the 35th Anniversary of Its Birth in North Carolina,* 61 N.C. MED. J. 249, 249 (2000).

28. *Id.* ("The first three PA students graduated at Duke on October 6, 1967."); DUKE UNIV., DEP'T. OF CMTY. HEALTH SCI., MODEL LEGISLATION PROJECT FOR PHYSICIAN'S ASSISTANTS (1970), *available at* https://medspace.mc.duke.edu/model-legislation-project-physicians-assistants-1970.

states.[29] Given that the Duke PA Program generated rapid interest in the new profession and served as the impetus for other medical institutions to start similar programs, the need for a framework for licensure and regulation was both evident and imperative.[30] Recognizing the urgency for uniform professional standards, the federal government awarded a contract to the Duke Department of Community Health Sciences for a project to design model legislation for the regulation of PAs in 1969.[31] Subsequently, several conferences ensued on the licensure and regulation of new medical professions, including PAs.[32] There was representation from all groups considered to have substantial interaction with these new healthcare professionals.[33] The primary goal was to craft model legislation to advance the posture of the profession.[34] This goal was guided by two core concepts.[35] First, since the PA role was nebulous and the concept still evolving, the legislation should exemplify patient safety and promote maximum role flexibility.[36] Second, because physicians are accountable for the care rendered by a PA, the physician should ultimately decide the PA's scope of practice.[37]

By 1971, the North Carolina General Assembly enacted a law authorizing PA practice.[38] The new law, embodied within Section 90-18 of the North Carolina General Statutes, amended the medical practice act and provided an exception for assistants to physicians.[39] According to the amendment, assistants who were both approved by and registered with the North Carolina Board of Medical Examiners were permitted to perform acts, tasks

29. DUKE UNIV., DEP'T. OF CMTY. HEALTH SCI., DUKE PHYSICIAN'S ASSOCIATE PROGRAM: LEGAL STATUS AND INSURANCE [INFORMATIONAL PAMPHLET SERIES] 3 (1966-1972) *available at* https://medspace.mc.duke.edu/sites/default/files/dumca_4891_PA-0132-03.jpg (regarding the legal framework and AG opinion).

30. *See* E. Harvey Estes, Jr. & Reginald D. Carter, *Accommodating a New Medical Profession: The History of Physician Assistant Regulatory Legislation in North Carolina*, 66 N.C. MED. J. 103, 104 (2005); Reginald D. Carter & Henry B. Perry, *Alternatives in Health Care Delivery: Emerging Roles for Physician Assistants*, *in* PHYSICIAN ASSISTANT: A GUIDE TO CLINICAL PRACTICE 78, 82 (Ruth Ballweg et al. eds., 5th ed. 2013).

31. Estes, Jr. & Carter, *supra* note 30, at 104.

32. *See id.* at 104-05 ("The first conference was held in Durham, North Carolina, on October 26 and 27, 1969" and the "second conference was held in Durham, North Carolina on March 1, 1970").

33. *Id.* at 104. Participants included nationally recognized experts on the licensure of health personnel, representatives from medicine and hospital administration in the state, members of the North Carolina legislature, educational representatives from Duke University School of Medicine and the PA Program, members of the newly graduated classes of PAs and their employing physicians, among numerous others.

34. Carter & Strand, *supra* note 27, at 250.

35. *Id.*

36. *Id.*

37. *Id.*

38. *See* 1971 N.C. Sess. Laws 1193 (providing an exception to the medical practice act relating to assistants to physicians).

39. N.C. GEN. STAT. ANN. § 90-18(14) (WEST 1971).

or functions at the direction and under the supervision of physicians.[40] Additionally, the services that the PA provided had to be within the field or fields for which the PA had been trained, approved, and registered by the North Carolina Board.[41]

At the close of 1972, PA legislation had been enacted in twenty-four states and contemplated in fifteen additional states.[42] The remaining eleven state legislatures had yet to examine any PA measures.[43] The bills at that time typically took one of two distinct forms: *delegatory*—those that merely altered the state medical practice act and allowed PAs to provide care with physician supervision, or *regulatory*—those that authorized a particular regulatory agency, typically the state board of medical examiners, to promulgate rules and regulations regarding the academic and employment qualifications of PAs.[44] The sole exception to these approaches was Colorado, which incorporated both types of provisions.[45] Colorado's regulatory statute delineated specified conditions for PAs employed by physicians who worked chiefly in pediatrics, and at the time, the statute was the only PA law to institute licensure requirements.[46] Proponents lauded general delegatory statutes for their flexibility because they facilitated the utilization of PAs for a wide variety of tasks.[47] Those supporting delegatory legislation opined that the statutes ensured optimal patient safety by holding the physician liable for any and all PA wrongdoings.[48] This absolute and significant threat was more than enough motivation for a physician to invariably hire competent PAs, provide sufficient supervision, and assure adequate patient safeguards.[49] However, these types of laws did have some disadvantages.[50] For instance, the laws lacked formal identification or acknowledgement of the PA profession, and the absence of provisions for approving PA educational programs was starkly evident.[51] The latter facet was objectionable because it ran afoul of patient safety concerns and gave physicians vast discretion to employ and delegate a plethora of medical duties to anyone,

40. *Id.* § 90-18(14)(a)(b).

41. *Id.* § 90-18(14)(c).

42. Winston J. Dean, *State Legislation for Physician's Assistants: A Review and Analysis,* 88 HEALTH SERV. REP. 3, 3 (1973), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1616054/pdf/healthservrep00027-0005.pdf Legislation considered in the 15 other states was ultimately rejected.

43. *Id.*

44. *Id.* at 3, 6.

45. *Id.* at 6.

46. *Id.* Colorado's statute is commonly known as the Child Health Associate Law.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

regardless of their qualifications.[52]

The bulk of state legislatures repudiated statutes that simply amended the state medical practice act and allowed physician delegation of patient care tasks within their scope of practice to PAs they supervised.[53] This was due in large part to the fact that such laws allowed physicians to be the single arbiter of both the PA's educational criteria and medical duties.[54] Consequently, state legislatures enacted more comprehensive laws, endowing a designated regulatory body—usually the state board of medical examiners—the authority to adopt rules and regulations relevant to PA education and employment.[55] These types of laws diminished the malleability of the physician-PA teams at the time, but afforded greater patient safety because the PAs were required to satisfy fixed educational and skill requirements prior to their receiving consent for employment.[56] This also enabled physicians to recognize the qualifications necessary for safe and effective PA practice.[57] The general celerity of the regulatory process led to it being favored for its ability to promptly reflect new information and knowledge about PAs.[58] The regulatory approach had disadvantages, including the ability of regulators to establish differing educational and experience requirements—resulting in a lack of standardization and uniformity across the country.[59] In addition, state medical boards were lacking the capital, and often the proficiency, required to formulate and administer examinations for applicants or carry out accreditation functions applicable to training curriculums.[60]

Irrespective of the form of the legislation, twenty-four states enacted PA laws by the end of 1972.[61] Of these twenty-four, Colorado was the first and only state to permit limited prescriptive authority to graduates of the University of Colorado's child health program.[62] Eight of these states required the physician and the PA to submit a job description outlining the PA's scope of practice to the board for approval.[63] Additional health profession-

52. *Id.*
53. *Id.* at 6-7.
54. *Id.*
55. *Id.* at 7.
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.* at 3.
62. ASPEN HEALTH LAW CTR., PHYSICIAN ASSISTANT LEGAL HANDBOOK 14 (Aspen Publishers 1997).
63. Dean, *supra* note 42, at 7 ("To further protect patients from incompetence eight States (Alabama, California, Florida, Georgia, Iowa, Oregon, Washington, and West Virginia), either by legislation or regulation, require that physician and his proposed assistant to

als, fearing that physicians would delegate to PAs functions previously within the exclusive purview of their professions, also influenced PA scope of practice.[64] These included optometrists, dentists, and chiropractors who successfully advocated for statutory provisions to prohibit PAs from performing tasks that would constitute the practice of optometry, dentistry, and chiropractic.[65]

In the midst of the establishment of the profession and the enactment of various laws and regulations across the country, the national professional society for PAs, known as the American Academy of Physician Assistants ("Academy" or "AAPA"), was established and incorporated in the state of North Carolina in 1968.[66] Recognizing that the organization had no formal policy regarding the appropriate state regulation of PAs, the AAPA adopted as policy *Guidelines for State Regulation of Physician Assistants* ("*Guidelines*") through its House of Delegates in 1988.[67] The rationale for an adoption of key concepts in PA regulation was twofold.[68] The first reason was to facilitate standardized regulation of the profession between states in order to expedite increased flexibility of PA utilization.[69] The second was to assist the AAPA state and specialty PA organizations in their pursuit of an optimal practice environment.[70] By this time, thirty-four states required the physician-PA team and a designated regulatory agency to determine PA scope of practice.[71] Thirteen states allowed the PA's scope of practice to be within the sole purview of the physician-PA team.[72] In the District of Columbia and Kentucky, regulations on this issue were pending approval, and

submit to the board for approval a job description outlining the way in which the PA is to be used.").

64. *Id.* at 8.

65. *Id.*

66. *See* AM. ACAD. OF PHYSICIAN ASSISTANTS, *History of the PA Profession*, http://www.aapa.org/about_aapa/history.aspx (last visited Nov. 21, 2014) (noting that "[t]he medical community helped support the new profession and spurred the setting of accreditation standards, establishment of a national certification process and standardized examination, and development of continuing medical education requirements." The American Academy of Physician Assistants was formerly known as the American Association of Physician Assistants).

67. AM. ACAD. OF PHYSICIAN ASSISTANTS HOUSE OF DELEGATES, PROFESSIONAL AND SOCIAL ISSUES, REFERENCE COMMITTEE OF THE LEGISLATIVE AND GOVERNMENTAL AFFAIRS COMMITTEE, ENABLING LEGISLATION, PHILOSOPHY, RES. 88-P-1-LGA GUIDELINES FOR STATE REGULATION OF PHYSICIAN ASSISTANTS (1988).

68. AM. ACAD. OF PHYSICIAN ASSISTANTS, GUIDELINES FOR STATE REGULATION OF PHYSICIAN ASSISTANTS 2 (2013), *available at* https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=795.

69. *Id.*

70. *Id.*

71. AM. ACAD. OF PHYSICIAN ASSISTANTS, PHYSICIAN ASSISTANTS STATE LAWS AND REGULATIONS v-vi (5th ed. 1987).

72. *Id.*

in New Jersey, PAs could only work in federal facilities.[73] In Mississippi, the former attorney general stated that physicians could delegate certain procedures to competent medical auxiliary personnel.[74] Prescriptive authority had been authorized in seventeen states, and measures for granting such authority were pending in three states and the District of Columbia.[75]

In 1991, using the *Guidelines* to navigate its course, the Academy drafted its *Model State Legislation for Physician Assistants* ("*Model State Legislation*").[76] Consistent with the original concept of PA utilization, the scope of PA practice under the model legislation is determined by the PA's training, experience, and preferences, as well as what the supervising physician wishes to delegate.[77] It also displays a shift far afield from a regulatory micromanagement of physician-PA practices.[78] The model legislation authorizes physician-delegated prescriptive authority, including controlled substances in Schedules II through V, as well as limited dispensing authority.[79] The model legislation also incorporated provisions to clarify a PA's authority to request, receive, and distribute professional samples.[80] PAs who are delegated prescribers of controlled medications are required to register with the federal Drug Enforcement Administration.[81]

The *Model State Legislation* has undergone numerous revisions since its original draft to reflect changes in PA program accrediting agency standards and to incorporate other new provisions.[82] However, it consistently embodies two core concepts: first, regulatory authorities should license PAs to

73. *Id.*

74. Letter from Fernando A.F. Summer, Miss. Attorney Gen., to T. D. Lampton, M.D., Director of the Physician Assistant Program, Univ. of Miss. Med. Ctr., 1974 WL 31611 (May 28, 1974).

75. AM. ACAD. OF PHYSICIAN ASSISTANTS, *supra* note 71, at v-vi.

76. AM. ACAD. OF PHYSICIAN ASSISTANTS, MODEL STATE LEGISLATION FOR PHYSICIAN ASSISTANTS 2 (2013), *available at* http://www.aapa.org/WorkArea/DownloadAsset.aspx?id=548 [hereinafter MODEL STATE LEGISLATION].

77. *Id.* at 2, 4.

78. *Id.* at 2.

79. *Id.* at 2, 5. *See generally* 21 U.S.C.A. § 812 (a)-(c) (West, WestlawNext through P.L. 113-163 (excluding P.L. 113-128)). The United States has a drug policy that regulates the manufacture, importation, possession, use, and distribution of certain substances. Those substances and other drugs that are determined to be controlled substances within the purview of the CSA Controlled Substances Act are apportioned into five schedules. *Id.* A substance's schedule classification depends upon the existence of sanctioned medical use in treatment in this country, their respective abuse potential, and probability of provoking dependence when misused. *Id.* On the spectrum, substances in Schedule II have a high potential for abuse, which have the ability to cause acute psychological or physical dependence. Substances in Schedule V have a low potential for misuse compared to substances enumerated in Schedule IV and primarily include preparations containing limited amounts of various narcotics. *Id.*

80. MODEL STATE LEGISLATION, *supra* note 76, at 5.

81. *Id.* at 2.

82. *Id.* at 2.

practice medicine in collaboration with their physician partners, and second, the physician and PA should determine the PA's scope of practice.[83] Although the latter concept has always been a part of the *Model State Legislation,* state laws had to undergo decades of revisions before culminating in a movement toward a more PA and physician-determined scope of practice.[84] This occurred as medical boards discovered that it was both absurd and futile to itemize every task that a physician could conceivably and properly delegate to a PA.[85] By 1999, forty-six states and the District of Columbia had passed laws to allow physician-delegated prescriptive authority to PAs.[86] In more than three-quarters of those states, that authority included the ability to prescribe controlled medications.[87] Indiana, Louisiana, and Ohio were the only outlier states that authorized PA practice but continued to prohibit prescribing by PAs.[88]

In 2000, Mississippi became the fiftieth state to formally authorize PA practice, and in 2007, Indiana became the fiftieth state to grant PAs prescriptive authority.[89] Upon enactment of legislation to authorize PA practice in Mississippi, the medical board immediately adopted regulations to authorize PA prescribing.[90] As of the end of 2014, PAs are authorized to prescribe controlled medications in all but two states.[91]

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83. *Id.* at 1.

84. Ann Davis & Michael L. Powe, *Physician Assistants: Scope of Practice, Regulation and Reimbursement*, 18 J. MED. PRAC. MGMT. 81, 81 (2002) (indicating that the role of PAs in the United States has "undergone rapid evolution since the profession's inception 34 years ago" and that the "most recent trend has been a return to a more physician-determined scope of practice.").

85. *Id.* at 82.

86. AM. ACAD. OF PHYSICIAN ASSISTANTS, PHYSICIAN ASSISTANTS STATE LAWS AND REGULATIONS i (8th ed. 2000).

87. Davis & Powe, *supra* note 84 at 83.

88. *Id.*

89. *See* H.B. 846, 2000 Reg. Sess. (Miss. 2000). *See also* H.B. 1241, 115th Gen. Assemb.,1st Reg. Sess. (Ind. 2007). *See also* Ann Davis, PA-C, *Mississippi Enacts PA Licensing Act, All 50 States Now Authorize PA Practice*, AAPA NEWS, May 30, 2000, at 1 (stating that Mississippi was the last state to recognize PA practice). *See generally* RODERICK S. HOOKER ET AL., PHYSICIAN ASSISTANTS POLICY AND PRACTICE 408 (2010) (stating that by 2007 all states had permitted PA prescribing authority).

90. Davis, *supra* note 89, at 1 (indicating that on April 24, 2000, at 3:30 p.m. Mississippi Gov. Ronnie Musgrove signed H.B. 846, legislation to license and authorize the practice of physician assistants). *See also* ADVANCE HEALTHCARE NETWORK, *In the News: State PA News, Mississippi Board of Medical Licensure Adopts PA Rules*, 10 (Sept. 1, 2000), *available at* http://nurse-practitioners-and-physician-assistants.advanceweb.com/Article/In-the-News-2.aspx (asserting that the Mississippi State Board of Medical Licensure unanimously adopted regulations governing PA practice in the state on July 27, 2000 and that the rules went into effect on August 28, 2000).

91. DRUG ENFORCEMENT ADMINISTRATION, MID-LEVEL PRACTITIONERS AUTHORIZATION BY STATE 1, 1-7 (OCT. 29, 2014), *available at* http://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf (the only two states that indicate "NO" for PAs are Florida and Kentucky). *See* FLA. STAT. ANN. § 458.347(4)(f) (West, WestlawNext through Ch. 255 of 4

The United States regulates an extensive array of health professions and health occupations.[92] The enactment of state laws governing the licensure of PAs and other non-physicians has traditionally been amiable with the primary intent of protecting licensees and patients.[93] This is in sharp contrast to medical licensure laws enacted to remedy known misuse of self-sufficient practice.[94]

III. DETERMINANTS OF PA SCOPE—ABILITY *VS.* AUTHORITY

Scope of practice is a term used to describe the types of services a healthcare practitioner can provide.[95] It is important to recognize the difference between *professional* scope of practice and *legal* scope of practice.[96] Professional scope of practice is a profession's description of the services its members are trained and competent to perform.[97] Legal scope of practice is a term often used by states and other jurisdictions to define the activities of a licensed health professional.[98] Each jurisdiction has laws, licensing bodies, and in most cases, regulations that describe requirements for education and training, and legal scope of practice.[99] Within a state, a narrower governing body such as a hospital or clinic may refine the scope of practice for the individual practitioner, further limiting the licensee's scope to a specific range of services or specific procedures.[100] PA scope of practice is generally defined by four determinants: PA education, experience, and preference; physician delegation; facility credentialing and privileging; and state law and regulation.[101]

Sp. 'A' 23rd Leg. Sess.). *See also* KY. REV. STAT. ANN. § 311.856(2) (West, WestlawNext through 2014 legislation).

92. *See* HOOKER ET AL., *supra* note 89, at 408 (2010) (asserting that there are more than thirty-six regulated health professions in the United States and more than 200 health vocations).

93. *Id*, at 409 (asserting that these statutes have usually been "friendly" regulations enacted with the cooperation of the professions and occupations and designed to protect both the regulated personnel and the public from unqualified and unethical practitioners).

94. *See id.* at 409 (stating that unlike medical licensure laws, state licensure statutes for PAs, allied and auxiliary health personnel, and nurses were not enacted to correct abuses of independent entrepreneurial practice).

95. Catherine Dower et al., *It Is Time To Restructure Health Professions Scope-Of-Practice Regulations To Remove Barriers To Care*, 32 HEALTH AFF. 1971, 1972 (2013).

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. HOOKER ET AL., *supra* note 89, at 276.

101. *Id.* at 418. *See also* AM. ACAD. OF PHYSICIAN ASSISTANTS, STATE LAWS FOR PHYSICIAN ASSISTANTS 4 (14th ed. 2014) [hereinafter STATE LAWS 14TH ED.]. *See also* RUTH BALLWEG ET AL., PHYSICIAN ASSISTANT: A GUIDE TO CLINICAL PRACTICE 741 (5th ed. 2013).

A. Determinant 1: PA Education, Experience, and Preference

Scope of practice should be limited to those tasks which PAs are adequately prepared for based on their education, training, and clinical experience.[102] PA programs are structured to produce a graduate with a background as a medical generalist.[103] As such, academic institutions that include medical schools, universities, and colleges sponsor PA programs.[104]

Applicant prerequisites include three to four years of basic science college course work.[105] The majority of PA programs require an applicant to have a bachelor's degree.[106] Typically, programs are two years in length and award the student a master's degree.[107] A number of innovative approaches in preparing medical providers for primary care careers have emerged in PA programs, in part due to federal Title VII funding incentives for PA education.[108]

In 2011, approximately 6,545 PA graduates entered the workforce.[109] The same year, the applicant pool for entry into PA programs exceeded

102. *See* HOOKER ET AL., *supra* note 89, at 418.

103. Anita Duhl Glicken & Anthony A. Miller, *Physician Assistants: From Pipeline to Practice*, 88 ACAD. MED. 1883, 1887 (2013); *see also* James F. Cawley & P. Eugene Jones, *Institutional Sponsorship, Student Debt, and Specialty Choice in Physician Assistant Education*, 24 J. OF PHYSICIAN ASSISTANT EDUC. 4, 6 (2012) (stating that one of the policy goals of PAs is to contribute to generalist/primary care practice).

104. Cawley & Jones, *supra* note 103, at 4-5; *see also* P. Eugene Jones, *Physician Assistant Education in the United States*, 82 ACAD. MED. 882, 882-84 (2007) (implying that this based upon the PA schools listed); *see also* PHYSICIAN ASSISTANT EDUC. ASS'N, TWENTY-NINTH ANNUAL REPORT, 2012-2013: PHYSICIAN ASSISTANT EDUCATIONAL PROGRAMS IN THE UNITED STATES 6 (2014).

105. *See* PHYSICIAN ASSISTANT EDUC. ASS'N, TWENTY-SEVENTH ANNUAL REPORT, 2010-2011: PHYSICIAN ASSISTANT EDUCATIONAL PROGRAMS IN THE UNITED STATES 25 (2013), *available at* http://www.paeaonline.org/index.php?ht=a/GetDocumentAction/i/149930 (inferring such a requirement due to the many PA programs that selected prerequisite courses in the common sciences).

106. *See id.* at 25 (inferring from Table 18, that a majority of Programs require a Bachelor's degree).

107. *See* PHYSICIAN ASSISTANT EDUC. ASS'N, TWENTY-NINTH ANNUAL REPORT, 2012-2013: PHYSICIAN ASSISTANT EDUCATIONAL PROGRAMS IN THE UNITED STATES 7-9 (2014), *available at* http://www.paeaonline.org/index.php?ht=a/GetDocumentAction/i/156969 (showing that programs typically average 24 months in length (80% of all programs). The shortest program length was 19 months and the longest program length was 36 months. The majority of PA programs offer a master's degree.

108. *See* James F. Cawley, *Physician assistants and Title VII support,* 83 ACAD. MED. 1049, 1049-1056 (2008) "Some of these incentives are intended to improve the number of graduates going into generalist medicine, improving a balance of underrepresented minorities, and promote deployment into underserved communities."; *See also* Justine Strand and Reginald Carter, *Primary Care Training Grants Through Title VII, Section 747: The Duke Experience*, 14 PERSP. ON PHYSICIAN ASSISTANT EDUC. 25, 25-30 (2003).

109. Glicken & Miller, *supra* note 103, at 1884; *see also* Roderick S. Hooker & Ashley N. Muchow, *Supply of Physician Assistants: 2013-2026*, 27 J. AM. ACAD. PHYSICIAN ASSISTANTS, no. 3, 39, 39-45 (2014).

19,000 persons.[110] As of 2014, 190 accredited PA programs exist in the United States[111] and an additional seventy-five programs have applied for accreditation evaluation as reported by the Accreditation Review Commission on Education for Physician Assistants ("ARC-PA").[112] U.S. PA programs are intended to be educationally efficient by confining the curriculum to two to three years and continuing the education process year-round.[113]

B. Determinant 2: Physician Delegation

A major defining characteristic of PA scope of practice is physician delegation.[114] Unlike some health personnel who have unique skills, such as physical therapists and occupational therapists, the PA has a general skill set similar to that of a physician.[115] PAs perform acts of medical diagnosis and treatment that comprise the legal definition of medical practice.[116] The scope of services that PAs are trained to perform is broad, ranging from routine examinations and diagnostic maneuvers to prescribing medications, performing minor surgical procedures, and assisting at surgery.[117] In order for PAs to apply their skills in clinical practice, states require that PAs practice with a physician or group of physicians and are delegated specific tasks.[118]

However, for physicians with unlimited licenses to perform all medical functions, the critical questions become what medical functions they may

110. Glicken & Miller, *supra* note 103, at 1884.

111. *Accredited Programs: Program Data*, ACCREDITATION REV. COMM'N ON EDUC. FOR THE PHYSICIAN ASSISTANT, http://www.arc-pa.com/acc_programs/program_data.html (last visited Nov. 21, 2014).

112. *Notice of Actions – Accreditation Status*, ACCREDITATION REV. COMM'N ON EDUC FOR THE PHYSICIAN ASSISTANT (Oct. 27, 2014), http://www.arc-pa.com/documents /AccreditationActions2014S%2010.27.14%20web.pdf.

113. *See generally* PHYSICIAN ASSISTANT EDUC. ASS'N, TWENTY-SEVENTH ANNUAL REPORT *supra* note 106, at 10 (inferring efficiency from the length of the curriculum; the weeks spent in each phase and the vacation time included in the program length indicate it is a year-round program with vacation time dispersed throughout).

114. *See* Jane C. Record et al., *New Health Professions After a Decade and a Half: Delegation, Productivity and Costs in Primary Care*, 5 J. POL. POL'Y & L., no. 3, at 470, 472-80 (1980) [hereinafter *New Health Professions*].

115. Roderick S. Hooker, *Medical Care Utilization: MDPA/NP Comparisons in an HMO*, *in* PHYSICIAN ASSISTANTS: PRESENT AND FUTURE MODELS OF UTILIZATION 68 (S. F. Zarbock & K. Harbert eds., 1986). *See also* Richard E. Johnson & Donald K. Freeborn, *Comparing HMO Physicians' Attitudes Towards NPs and PAs*, 11 NURSE PRACT. 39-52 (1986). *See also* Richard E. Johnson et al., *Delegation of Office Visits in Primary Care to PAs and NPs: The Physicians' View*, 10 PHYSICIAN ASSISTANT, no. 1, 159-169 (1985).

116. Hooker, *supra* note 115, at 68-73; *See also* MD. CODE ANN., Health Occupations § 14-101(o) "'Practice medicine' means to engage, with or without compensation, in medical: (i) Diagnosis; (ii) Healing; (iii) Treatment; or (iv) Surgery."

117. *Id.*

118. *New Health Professions*, *supra* note 114, at 472.

delegate and under what conditions such delegations can be made.[119] One case in particular illustrates the legal precedent of physician task delegation.[120] The California Supreme Court case, *Whittaker v. Superior Court of Shasta County,*[121] is notable not only because of the court's handling of licensure elements, custom, and supervision in deciding the issue of delegation, but because of its influence on the development of the PA profession.[122] *Whittaker* involved the right of a neurosurgeon to use a trained surgical assistant to assist in brain surgery. Although it did not involve a licensed PA, the decision was a seminal event for the fledgling PA profession.[123] Roger G. Whittaker was a former Navy corpsman and Vietnam veteran, who had attended the Navy's Hospital Corpsman School and Operating Technician School.[124] He was attending the University of California on veterans' benefits and took a job as an assistant with the only practicing neurosurgeon within 275 miles in Redding, California. [125] The California State Board of Medical Examiners charged Whittaker with practicing medicine without a license because he operated a cranial drill to bore holes and excise skull flaps during neurosurgical operations.[126] The State Board also charged the surgeon with aiding and abetting an unlicensed person to practice medicine.[127]

During his testimony, the chairman of the board of Redding Memorial Hospital admitted that the defendant was a "better neurosurgical assistant" than the chairman.[128] Nevertheless, the court found Whittaker guilty of drilling burr holes without a license, and found the surgeon guilty of aiding and abetting him.[129] However, the jury determined that their services were beneficial to the patient and the community.[130] The court imposed nominal penalties and suspended sentences of thirty days in jail—Whittaker was

119. *See* JANE C. RECORD, *The findings and policy implications, in* STAFFING PRIMARY CARE IN 1990, SPRINGER SERIES ON HEALTH CARE AND SOCIETY 131–153 (1981). *See also* JANE C. RECORD, *The Productivity of New Health Practitioners*, *in* STAFFING PRIMARY CARE IN 1990, SPRINGER SERIES ON HEALTH CARE AND SOCIETY 37–52 (1981).

120. Reginald Carter et al., *People v. Whitaker: The Trial and its Aftermath in California*, 19 J. PHYSICIAN ASSISTANT EDUC. 44, 45-46 (2008).

121. Whittaker v. Superior Court, 68 Cal.2d 357, 359 (Cal. 1968).

122. Douglas Condit, *Our Military Heritage*, 17 PHYSICIAN ASSISTANT 58, 62 (1993). *See also* Carter et al., *supra* note 120, at 47-50 (discussing the trial and its outcome and subsequent impact on the field).

123. HOOKER ET AL., supra note 89, at 433. *See also* Carter et al., *supra* note 120, at 48-50.

124. Condit, *supra* note 122, at 62.

125. *Id.*

126. Carter et al., *supra* note 120, at 47.

127. Condit, *supra* note 122, at 62; HOOKER ET AL., *supra* note 89, at 433.

128. Condit, *supra* note 122, at 62.

129. Carter et al., *supra* note 120, at 46-48.

130. Condit, *supra* note 122, at 62.

fined $50 and his employer $200.[131] A jury empanelled before a justice of the Peace Court found both parties guilty, reasoning that the surgeon had sufficient time to call another physician to assist him, but did not try to do so.[132] The jury was to consider the evidence of custom and usage of the medical practice in California as the prosecutor had presented.[133]

The *Whittaker* judgment was successfully appealed in large part due to its importance as a test of the right of a physician or surgeon to use an assistant under conditions not constituting a medical emergency.[134] The case was significant for its allowance of prevailing "custom and usage of the medical practice" in the state to determine the propriety of a physician's delegation and supervision of patently medical, but essentially mechanical, functions.[135]

During the case Dr. Eugene Stead, the founder of the PA program at Duke University, served as an expert witness.[136] Stead testified that Whittaker provided a much-needed medical service and supported the concept that the physician should have clear legal authority to delegate medical tasks to appropriately trained assistants.[137] Whittaker would eventually become a PA, graduating from Duke's program.[138]

Delegation within the physician-PA team is facilitated by the educational design of PA programs.[139] Because PAs and physicians train using similar curriculum, training sites, faculties, and facilities, physicians, and PAs develop a similarity in medical reasoning that leads to standardized thought in the clinical workplace.[140]

C. Determinant 3: Facility Credentialing and Privileging

Credentialing and privileging are the processes used by licensed healthcare facilities to authorize licensed PAs, physicians, and others to practice in the institution.[141] Credentialing is the process used to evaluate the qualifications and practice history of an applicant for medical staff privileges.[142] The intent of credentialing is to safeguard the public and the

131. *Id.*
132. HOOKER ET AL., *supra* note 89, at 433.
133. *Id.*
134. *Id.*
135. *Id.*
136. *Id.*
137. *See id.*
138. *See id. See also* Carter et al., *supra* note 120, at 48; Condit, *supra* note 122, at 62.
139. *See* HOOKER ET AL., *supra* note 89, at 117-18.
140. George L. White, Jr. et al., *Physician Assistants and Mississippi*, 35 J. MISS. ST. MED. ASS'N 353, 355 (1994).
141. *See* HOOKER ET AL., *supra* note 89, at 276.
142. *Id.* at 276-77.

institution.[143] This process involves a review of the PA's education and training, including postgraduate studies, continuing medical education, certification, and state licensure.[144] Additionally, a thorough background check, including any past disciplinary actions or malpractice claims, may be sourced.[145] The credentialing process typically takes place as the individual seeks hospital privileges.[146]

Once a PA is credentialed by a hospital or licensed facility, they are authorized to engage in a specific scope of practice through a process known as "privileging."[147] The standards of the Joint Commission—a major hospital accrediting agency—require hospitals to credential and privilege PAs in a manner similar to that of physicians.[148] After privileges are granted, the PA is permitted to see patients, assist in surgery, or perform other specific duties delegated by the supervising physician.[149]

D. Determinant 4: State Law and Regulation

Another determinant of PA scope of practice is state law.[150] Medical boards are charged with administering systems to monitor provider behavior, ensure public safety, and provide appropriate medical discipline.[151] As such, most jurisdictions license and regulate PAs through the state medical board, but eight states have regulatory bodies strictly for PAs.[152] Nearly all of the states where PAs are regulated by the medical board have PA committees.[153] All states require two basic criteria for licensure: graduation from a PA program accredited by ARC-PA, and passage of the Physician Assistant National Certification Examination (PANCE) administered by the National Commission on Certification of Physician Assistants ("NCCPA").[154] The NCCPA's PANCE exam functions as the *de facto* li-

143. *Id.*
144. *Id.*
145. *Id.*
146. *Id.*
147. *See id.* at 275-82.
148. *See generally* HOOKER ET AL., *supra* note 89, at 420 (stating that the Joint Commission evaluates an organization's credentialing program and that, as a general matter, credentialing programs for PAs are conducted in a manner parallel to those for physicians).
149. *See* HOOKER ET AL., *supra* note 89, at 276.
150. *See id.* at 418.
151. *Id.* at 420. *See also* FEDERATION OF STATE MEDICAL BOARDS, REPORT OF THE FSMB WORKGROUP ON INNOVATIONS IN STATE BASED LICENSURE 2 (2014), *available at* http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/report_of_state_innovations_adopted.pdf.
152. *See* STATE LAWS 14TH ED., *supra* note 101, at 3 (States with a regulatory bodies strictly for PAs include Arizona, California, Iowa, Massachusetts, Michigan, Rhode Island, Utah, and Texas).
153. *Id.*
154. *Id.*

censing examination for PAs.[155] Most medical boards require continuing medical education ("CME") as a condition of license renewal.[156] CME can be earned in lecturer-learner format at conferences and seminars or online.[157] However, a wide range of alternatives for earning CME credits emerged in recent years.[158] For instance, CME may also be earned though journal-based activities, like completing a set of questions derived from a specific journal article.[159] Most medical and osteopathic licensing boards condition license renewal on a specific number of earned CME credits.[160] The same is true for almost all PA licensing boards.[161]

By 2014, thirty-four states had abandoned the concept that a medical board or other regulatory agency should micromanage PA-physician teams.[162] For example, regulations adopted by the Wyoming Board of Medicine specify that:

> [T]he Board does not recognize or bestow any level of competency upon a PA to carry out a specific task. Such recognition of skill is considered the responsibility of the supervising physician. However, a PA is expected to perform with similar skill and competency and to be evaluated by the same standards as the physician in the performance of assigned duties.[163]

The other sixteen states and D.C. require some degree of board approval

155. *Id.* at 6.

156. *Continuing Medical Education: Board-by-Board Overview*, FED'N OF STATE MED. BDS. (last updated Mar. 2014), *available at* http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/GRPOL_CME_Overview_by_State.pdf.

157. *CME Content: Definition and Examples*, ACCREDITATION COUNCIL FOR CONTINUING MED. EDUC., http://www.accme.org/requirements/accreditation-requirements-cme-providers/policies-and-definitions/cme-content-definition-and-examples (last visited Oct. 5, 2014). *Continuing Medical Education,* NAT'L COMM'N ON CERTIFICATION OF PHYSICIAN ASSISTANTS, http://www.nccpa.net/ContinuingMedicalEducation (last visited Oct. 5, 2014). RUTH BALLWEG ET AL., *supra* note 30, at 58 (5th ed. 2013).

158. ACCREDITATION COUNCIL FOR CONTINUING MED. EDUC., 2013 ANNUAL REPORT EXECUTIVE SUMMARY 1 (2013), *available at* http://www.accme.org/sites/default/files/630_2013_Annual_Report_20140715.pdf ("The ACCME's information on participation in activity types shows the growth of participation in individualized, self-directed CME such as Internet searching and learning.").

159. *How Does the ACCME Define a Journal-based CME Activity?,* ACCREDITATION COUNCIL FOR CONTINUING MED. EDUC., http://www.accme.org/ask-accme/how-does-accme-define-journal-based-cme-activity (last visited Oct. 5, 2014).

160. Stephen H. Miller et al., *Continuing Medical Education, Professional Development, and Requirements for Medical Licensure: A White Paper of the Conjoint Committee on Continuing Medical Education*, 28 J CONTINUING EDUC. HEALTH PROF. 95 (2008).

161. *See* STATE LAWS 14TH ED., *supra* note 101, at 6-7 (14th ed., Rev. 2014).

162. *See generally* STATE LAWS 14TH ED., *supra* note 101 (14th ed., Rev. 2014) (by adding up the individual states whose provisions qualify).

163. 5 WYO. CODE. R. §4(d) (2009), *available at* http://wyomedboard.state.wy.us/PDF/index/Chapter5.pdf.

of an individual PA's scope of practice.[164] For example, Idaho regulations require all "specialized procedures" to be approved by the board.[165] All state PA practice acts specify some degree of physician oversight of care provided by PAs, with all but one using the word "supervision" to describe this oversight.[166] Supervision is legally defined as "responsible control." Control implies the establishment of the overall limits of and the policies to be followed by the supervised professional.[167] Although all state laws require that PAs practice with physician supervision, no state requires that the physician be continuously onsite.[168] All state laws require the ready availability of the physician for consultation and with rare exception, authorize availability via telecommunication.[169] A typical definition of supervision is provided in a New York statute: "[s]upervision shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place where such services are performed."[170]

An increasing number of states authorize the specific elements of supervision to be determined at the practice site, based on the complexity of patient problems common to the practice, the training and experience of the PA, and the setting in which care is rendered.[171] Generally, the more complex the task and the greater the potential risk to the patient, the more direct and explicit the expectations for physician availability.[172]

In the eyes of the law, the PA serves as the agent of the physician.[173]

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164. *See generally* STATE LAWS 14TH ED., *supra* note 101 (14th ed., Rev. 2014) (by adding up the individual states whose provisions qualify).

165. IDAHO ADMIN. CODE r. 22.01.03.030.03 (2004).

166. ALASKA ADMIN. CODE tit.12, § 40.430. *See generally,* STATE LAWS 14TH ED., *supra* note 101 (14th ed., Rev. 2014) (demonstrating that the word used in all states but Alaska is "supervision").

167. Gara & Davis, *supra* note 14, at 744.

168. *Id.* at 81.

169. *See generally* STATE LAWS 14TH ED., *supra* note 101 (referring to each state's provisions on physician supervision). *See specifically* MINN. STAT. ANN. § 147A.01 Subd. 24 (2014) (defining "supervision" to mean overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required so long as the supervising physician and physician assistant are or can be easily in contact with one another by radio, telephone, or other telecommunication device. The scope and nature of the supervision shall be defined by the individual physician-physician assistant delegation agreement).

170. N.Y. EDUC. LAW § 6542 (West 2013).

171. *See generally* STATE LAWS 14TH ED., *supra* note 101 (referring to each state's provisions on scope of practice. As of 2014, twenty-five states and the District of Columbia allow the parameters of scope of practice to be determined at the practice site).

172. Gara & Davis, *supra* note 14, at 742.

173. *See* BLACK'S LAW DICTIONARY 62 (6th ed. 1990) ("A relationship between two persons, by agreement or otherwise, where one (the agent) may act on behalf of the other (the principal) and bind the principal by words and actions.").

Agency refers to a legal relationship whereby one person acts for or represents another by the latter's authority.[174] The agency relationship is a fundamental legal concept that is relevant to those situations wherein the PA acts on behalf of the supervising physician.[175] Agency authority may be apparent or inherent.[176] When apparent, the agent's authority is communicated to the third party by written or spoken words, or any other conduct of the principal which reasonably causes the third person to believe the principal consents to have the act done on his behalf by the person purporting to act for him.[177] Under inherent agency power, the power of the agent is derived solely from the agency relationship and exists for the protection of persons harmed by or dealing with the agent.[178] Authority also may either be express, in which authority is directly granted upon the agent in express terms, or implied, in which the authority is necessary, usual, and proper to accomplish or perform the main authority expressly delegated to the agent.[179]

Under the theory of apparent authority, a principal-physician holds out an agent-PA as one who possesses certain authority, in a way that would cause or allow a third party to believe the agent possesses such authority.[180] Principals that employ PAs have a legal duty to their prospective patients to provide care.[181] Most state laws restrict a PA's scope of practice to the supervising physician's scope of practice.[182] However, AAPA's model legislation and the PA regulations in Maine provide that the PA's scope of practice may exceed the physician's scope so long as adequate provisions for consultation and referral are in place.[183]

In general terms, the most practical decisions about scope of practice are made at a level where the needs of the individual patient can be best evalu-

174. *Id.*

175. Gara & Davis, *supra* note 14, at 743.

176. *See generally* STATE LAWS 14TH ED., *supra* note 101 (referring to each state's provisions on scope of practice. As of 2014, twenty-five states and the District of Columbia allow the parameters of scope of practice to be determined at the practice site).

177. Gara & Davis, *supra* note 14, at 742.

178. *See* BLACK'S LAW DICTIONARY 62 (6th ed. 1990) ("A relationship between two persons, by agreement or otherwise, where one (the agent) may act on behalf of the other (the principal) and bind the principal by words and actions.").

179. *Id.*

180. BLACK'S, *supra* note 173, at 96.

181. David J. Bissonette, *The Derivation of Authority For Medical Order Writing by PAs*, 4 J. AM. ACAD. PHYSICIAN ASSISTANTS 358, 361 (1991).

182. ALASKA ADMIN. CODE tit.12, § 40.430. *See generally* AM. ACAD. OF PHYSICIAN ASSISTANTS, STATE LAWS AND REGULATIONS (14th ed., Rev. 2014) (referring to states limiting PA scope of practice to the supervising physician's scope of practice).

183. 02-373-2 ME. CODE R. §6. *See also* AM. ACAD. OF PHYSICIAN ASSISTANTS, MODEL STATE LEGISLATION FOR PHYSICIAN ASSISTANTS 2 (2013), *available at* http://www.aapa.org/WorkArea/DownloadAsset.aspx?id=548.https.

ated and served.[184] For example, if several PAs and physicians are equally qualified and available to perform a procedure, but one speaks the language of the patient, the provider who can describe the procedure in the patient's own language is the better choice.[185] Patient preference has a role to play as well.[186] When possible, the preferences of individual patients should help determine which qualified provider is involved in specific aspects of their care.[187]

Sometimes the most illogical decisions on scope are made in the state legislature.[188] An example of this occurred when the Minnesota state legislature, considering legislation to improve the PA practice act, succumbed to outside pressure from certified registered nurse anesthetists and barred PAs from administering certain types of anesthesia.[189] The legislature ultimately passed the bill and the prohibition became law.[190] This led to similar anesthesia bans in a handful of other states.[191] Since the creation of the PA profession, it has been standard practice for PAs to be trained to perform a wide variety of medical procedures.[192] However, some medical boards have been slow to relinquish control of specified procedures to other professions.[193]

Ultimately, the PA-physician team best determines PA scope of prac-

184. RUTH BALLWEG ET AL., *supra* note 101, at 742 (5th ed. 2013).

185. Suad Ghaddar et al., *Innovative Approaches to Promote a Culturally Competent, Diverse Health Care Workforce in an Institution Serving Hispanic Students,* 88 ACAD. MED.1870 (2013) ("The reasons that underrepresentation leads to poor health outcomes and poor health care quality include cultural distance and language discordance issues between patients and health care providers.").

186. BARRY CASSIDY ET AL., ETHICS AND PROFESSIONALISM: A GUIDE FOR THE PHYSICIAN ASSISTANT 25 (2008).

187. *Id.*

188. Dower et al., *supra* note 95, at 1973.

189. S. 258, 79th Leg., Reg. Sess. (Minn. 1995).

190. MINN. STAT. ANN. § 147A.09 (1) (West 2014) (stating that PA authority to prescribe, administer, and dispense drugs excludes anesthetics, other than local anesthetics, injected inn connection with an operating room procedure, inhaled anesthesia and spinal anesthesia).

191. *See* LA. REV. STAT. ANN § 37:1360:31 (2005); MISS. CODE ANN. § 73-26-5 (West 2014); MO. REV. STAT. § 334.735 (2014); OHIO REV. CODE ANN. § 4730.091 (West 2006).

192. AM. ACAD. OF PHYSICIAN ASSISTANTS ET AL., COMPETENCIES FOR THE PHYSICIAN ASSISTANT PROFESSION 3 (Rev. 2012) ("Physician assistants are expected to. . .perform medical and surgical procedures essential to their area of practice.").

193. Letter from Susan S. DeSanti et al., Director, F.T.C. Office of Policy Planning, to Patricia E. Shaner, Office of General Council, Al. State Board of Med. Examiners (Nov. 3, 2010) ("Because the proposed rule effectively prohibits non-physicians from providing interventional pain treatment, and physicians from delegating authority to provide such treatment to other licensed health care professionals, the Proposed Rule appears to prevent CRNAs from performing many of the pain management procedures that the Board of Nursing considers to be within the scope of CRNA practice in Alabama, subject to physician supervision.").

tice.[194] Theoretically, the closeness of interdependent individuals sharing responsibilities for outcomes of patients and communities produces performance feedback, trust, and rewards.[195] The outcomes of improved patient physical and emotional health when teams are involved in their care may in fact be the feedback that keeps the PA-physician team functioning and the scope of practice evolving.[196]

IV. PRIMARY, SPECIALTY, QUALITY

The advent of the PA profession brought new players into the arena of medical practice and set up new relationships in the delivery of patient care.[197] Key to the introduction and acceptance of the PA concept was the legal premise that PAs would have a defined relationship with physicians and would practice medicine in partnership with their physician colleagues.[198]

In the 1970s, Eugene Schneller, a medical sociologist, observed PAs in the field.[199] Schneller's aim was to define and describe the activities and measure the performance of the newly introduced PA in medical practice.[200] Among his observations was his description of the physician-PA clinical relationship, which he termed "negotiated performance autonomy."[201] This notion describes the PA-physician relationship as an evolutionary process where the PA initially demonstrates a capability to perform medical tasks that, in turn, leads to the delegation of more and more medical responsibilities.[202] Key to this concept of increasing delegation is the reward of autonomy to the PA in performing clinical work.[203] As the physician gains trust in the PA, the PA takes on an increasing extent of medical tasks and does so on an autonomous basis.[204] Once the PA masters a series of diagnostic and

194. Gara & Davis, *supra* note 14, at 741-42.

195. Eric Sundstrom et al., *Work Teams: Applications and Effectiveness*. 45 Am. Psychologist 120 (1990).

196. Douglas W. Roblin et al., *An Evaluation of the Influence of Primary Care Team Functioning on the Health of Medicare Beneficiaries*, 68 MED. CARE RES. & REV. 177, 177-201 (2011); *see also* Christine M. Everett et al., *Division of Primary Care Services Between Physicians, Physician Assistants, and Nurse Practitioners for Older Patients with Diabetes*, 70 MED. CARE RES. & REV. 531, 531-41 (2013).

197. *History of the PA Profession*, AM. ACAD. OF PHYSICIAN ASSISTANTS, http://www.aapa.org/threeColumnLanding.aspx?id=429 (last visited Nov. 21 2014).

198. *Id.*

199. EUGENE S. SCHNELLER, THE PHYSICIAN'S ASSISTANT: INNOVATION IN THE MEDICAL DIVISION OF LABOR xxi (Lexington Books 1978).

200. *Id.* at 47.

201. *Id.* at 121.

202. *Id.*

203. *Id.* at 122.

204. *See generally id.* at 123 (hypothesizing from interviews with PA recruits, that as a PA is intellectually challenged, and is more involved in patient communication, the PA is

patient management tasks, the PA becomes more independent in delivering these services within the practice.[205] In time, and depending on the specialty and setting, the PA may reach the point where he or she can autonomously perform over ninety percent of the clinical tasks required in the practice.[206] The PA's ability to perform necessary tasks in that particular practice approaches that of the physician.[207] As the PA sees patients and determines diagnoses and management strategies with little to no physician consultation, he or she becomes an autonomous colleague in the practice.[208]

Negotiated performance autonomy captures the essence of the optimal PA-physician relationship and helps to explain the success of the PA profession over the past fifty years.[209] PAs are seen as essential healthcare professionals in the American healthcare workforce and are in high demand in the medical marketplace.[210] This sociologic concept may explain why PAs appear to be satisfied in their roles.[211] While the casual observer might think that requiring a provider to have a legal relationship with a physician might result in substantial career frustration and burn out, that is not the case.[212] Career satisfaction surveys consistently show that PAs are satisfied in their choice and find a great deal of fulfillment in their work.[213] Recent assessment of PA satisfaction shows that nearly two-thirds of all PAs are satisfied with their choice of career.[214]

Negotiated performance autonomy results in the capability of the PA to gradually assume responsibility for the vast majority of medical tasks per-

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more likely to use judgment and become more independent in delivering patient care).

205. *See id.*

206. *See New Health Professions*, *supra* note114, at 475.

207. SCHNELLER, *supra* note 199, at 124.

208. *Id.* at 117.

209. James F. Cawley & E. Bush, *Levels of Supervision Among Practicing Physician Assistants*, 28 J. AM. ACAD. PHYSICIAN ASSISTANTS (forthcoming 2015).

210. Roderick S. Hooker et al., *Career Flexibility of Physician Assistants and the Potential for more Primary Care*, 29 HEALTH AFF. 880, 883 (2010).

211. *Id.* at 884. *See also* Carol Biscardi et al., *Practice Characteristics and Lifestyle Choices of Men and Women Physician Assistants and the Relationship to Career Satisfaction*, 42 JOURNAL OF ALLIED HEALTH, 157, 157- 162 (2013) ("Sixty-five percent of men and women completely agreed that they are satisfied with their career. Eighty-three percent of men and women PAs believed that they can balance their personal and professional responsibilities. While the sample was small, it does represent the demographics of PAs currently in practice and thus supports the assumption that the PA profession affords the ability to balance responsibilities and promotes career satisfaction.").

212. *See* Donald K. Freeborn et al., *Satisfaction and Well-being of Primary Care Providers in Managed Care*, 25 EVAL. & THE HEALTH PROF. 239, 250-51 (2002) (indicating that a 1999 survey conducted by Kaiser Permanente Northwest found that "more than 80% of PA/NPs and physicians were satisfied with their medical careers.").

213. *Id.*

214. Bacardi *supra* note 15 at 157 and 159. (2014).

formed by the physician and required in a medical practice setting.[215] It appears to be a significantly underappreciated factor in the success and acceptance of the PA in U.S. medicine.[216]

The adaptability of the profession has also contributed to its success and acceptance.[217] All PA educational programs are required to adhere to uniform accreditation standards that include a general medical education focus.[218] Unlike physicians, who enter specialties through residency and fellowship training, all PAs receive the same training and enter specialties after graduation. PAs who maintain current certification by the NCCPA are required to demonstrate their generalist medical knowledge by taking and passing the NCCPA's PA National Recertification Examination every ten years.[219] This assures that PAs remain up to date on medical treatments and are able to draw from a deep pool of medical knowledge, which in turn allows the PA to adapt to a wide variety of medical specialties and subspecialties.[220]

A. PAs and Primary Care

According to the Institute of Medicine, primary care is the provision of integrated, accessible health care services by clinicians who are competent to deliver a large majority of personal health care needs, who develop a sustained partnership with patients, and practice medicine in the context of family and community.[221] In the U.S., primary care incorporates the specialties of family medicine, general internal medicine, and general pediatrics.[222] The primary care field contains the largest concentration of PAs.[223]

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215. *New Health Professions*, *supra* note 114, at 472–480.

216. R. E. Johnson et al., *Delegation of Office Visits in Primary Care to PAs and NPs: The Physicians' View*, 9 PHYSICIAN ASSISTANT 159, 159-61 (1985).

217. D. Fisher & W. Stanhope, *Physician Assistants Achieve Wide Acceptance in Health Care Field,* 2 FORUM, no. 4, 1978, 6, at 6-10.

218. *See generally* ACCREDITATION REV. COMM'N ON EDUC. FOR THE PHYSICIAN ASSISTANT, ACCREDITATION STANDARDS FOR PHYSICIAN ASSISTANT EDUCATION. 1-30 (4th ed. 2013), *available at* http://www.arc-pa.org/documents/Standards4theditionwithclarifyingchanges9.2013%20FNL.pdf (a PA program cannot exist nor function unless it is accredited. Their graduates would not be eligible to take the PANCE. Functionally, every existing PA program has to hold accreditation status.).

219. Nat'l Comm'n on Certification of Physician Assistants, Certification Maintenance, http://www.nccpa.net/CertMain (last visited Nov. 15, 2014).

220. *Id.*

221. INST. OF MED., DEFINING PRIMARY CARE: AN INTERIM REPORT 1 (Molla Donaldson et al. eds., Nat'l Acad. Press 1994), *available at* http://www.nap.edu/openbook.php?record_id=9153&page=1.

222. Barbara Starfield et al., *Contribution of Primary Care to Health Systems and Health*, 83 MILBANK Q. 457, 460 (2005).

223. AM. ACAD. OF PHYSICIAN ASSISTANTS, PHYSICIAN ASSISTANT CENSUS REPORT: RESULTS FROM THE 2010 AAPA CENSUS 15 (2010), *available at* http://www.aapa.org/workarea/downloadasset.aspx?id=1454 [hereinafter 2010 AAPA CENSUS]. Approxi-

Due to its generalized applicability, primary care has a positive effect on health, cost, and quality.[224] Patients that receive regular primary care services tend to be healthier, incur less cost, and suffer from fewer complications.[225] Conversely, patients without access to primary care generally incur higher healthcare costs and have poorer health outcomes.[226] There is widespread agreement that a greater primary care capacity in the United States is needed.[227] The Patient Protection and Affordable Care Act ("ACA") exposed the potential inability of America's healthcare workforce to meet expected demands, particularly in primary care.[228] Further, ACA's Medicaid coverage is predicted to increase the annual number of primary care visits by as much as twenty-four million by 2019.[229] Full and expanded utilization of PAs and their skills is vital to meeting this shortage and expanding access to primary care.[230] PAs are increasingly involved in specialty and subspecialty care, with the second largest percentage of PAs practicing in surgical subspecialties.[231]

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mately 31% of PAs work in the primary care field. *Id.*

224. *See generally* Thomas Bodenheimer et al., *Improving Primary Care for Patients with Chronic Illness*, 288 J. AM. MED. ASS'N 1909 (2002) (examining research evidence that demonstrates that components of the chronic care model can improve quality of care and can reduce the costs of obtaining that care).

225. *See generally* INST. OF MED., COMMITTEE PRIMARY CARE: AMERICA'S HEALTH IN A NEW ERA 69 (Molla S. Donaldson et al. eds., Nat'l Acad. Press 1996); Starfield, *supra* note 222, at 478. The facts cited in the paper by Starfield demonstrate that having effective primary care systems in place in a health system results in improvements in health care access, cost, and quality. *Id.* Michael Chernew et al., *Would Having More Primary Care Doctors Cut Health Spending Growth?*, 28 HEALTH AFF., 1327, 1327-35 (2009); James Macinko et al., *Quantifying the Health Benefits of Primary Care Physicians Supply in the US*, 37 INT'L J. HEALTH SERVICES RES., 111, 111-26 (2007).

226. Stephen M. Petterson et al., *Having a Usual Source of Care Reduces ED Visits*, 79 AM. FAM. PHYSICIAN 94, 94 (2009). *available at* http://www.aafp.org/afp/2009/0115/p94.html.

227. T. Bodenheimer & H. Pham, *Primary Care: Current Problems and Proposed Solutions,* 29 HEALTH AFF. 799, 799-805 (2010).

228. U.S. DEP'T HEALTH & HUMAN SERVS., PROJECTING THE SUPPLY AND DEMAND FOR PRIMARY CARE PRACTITIONERS THROUGH 2020 1 (2013), *available at* http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf.

229. Adam N. Hofer et al., *Expansion of coverage under the Patient Protection and Affordable Care Act and Primary Care Utilization*, 89 MILBANK Q. 69, 69 (2011).

230. MINN. DEP'T OF HEALTH, HEALTH WORKFORCE SHORTAGE STUDY REPORT: REPORT TO THE MINNESOTA LEGISLATURE 34 (2009), *available at* http://www.health.state.mn.us/healthreform/workforce/WorkforceFinalReport.pdf.

231. 2010 AAPA CENSUS, *supra* note 230, at 15; *see also* Am. Acad. Of Physician Assistants, Specialty Practice Issue Brief: Physician Assistants in Surgery 1 (2011), *available at* http://www.aapa.org/WorkArea/DownloadAsset.aspx?id=651 ("Twenty-five percent (19,000) of the nearly 75,000 clinically practicing PAs work in surgical specialties or subspecialties.").

B. PA Care – Acceptance, Content, and Quality

Quality of care is difficult and challenging to measure since it comes with an array of changing concepts, criteria, and reliability.[232] However, quality of care can be assessed by a number of measures that can assure the public that a PA is functioning in a safe and effective manner and that the quality is comparable to that of physicians in the same setting.[233] In fact, PA utilization in medical practices has grown, partly as result of perceived quality of care PAs deliver,[234] which some health services experts describe as indistinguishable from that of physician care.[235]

Public acceptance and familiarity with PAs is fairly well established in American culture.[236] In fact, one in four patients has received medical advice or treatment from a PA.[237] With respect to income, education, insurance status, self-assessment of health status, or rural versus urban location, recipients of care from PAs did not differ from recipients of care from physicians. [238] Notably, Medicare beneficiaries indicated that the levels of satisfaction of care provided by a physician, PA or NP was the same.[239] Similarly, studies on patient satisfaction show that patients are satisfied with care when their needs are met, regardless of the provider.[240]

The United States has seen a high level of patient acceptance of PA ser-

232. *See generally* Avedis Donabedian, *Evaluating the Quality of Medical Care,* 83 MILBANK Q. 691, 691-729 (2005) (measures of quality of care are often subjective, prone to bias, and dependent on patient perceptions that may or may not reflect improvement in health status).

233. *Id.* at 692-99.

234. *Id.; see also* Michael J. Dill *et al., Survey Shows Consumers Open to a Greater Role For Physician Assistants And Nurse Practitioners*, 32 HEALTH AFF. 1135, 1139-40 (2013) (indicating that a survey conducted by the Association of American Medical Colleges "suggests that most US adults seeking medical care are familiar with physician assistants and nurse practitioners and have, indeed, relied on them at some point for their care.").

235. Harold C. Sox, Jr., *Quality of Patient Care by Nurse Practitioners and Physician's Assistants: A Ten Year Perspective*, 91 ANN. OF INTERNAL MED. 459, 461 (1979).

236. *See* Dill et. al, *supra* note 234, at 1139 (demonstrating that surveys of the general public typically show a good level of familiarity with the role of the PA).

237. Arch G. Mainous III et al., *Physician Extenders: Who is Using Them?,* 24 FAM. MED. 201, 201 (1992). A 1992 report based on findings from a random sample of 687 adults surveyed by telephone in the Kentucky Health Survey indicated that 1 in 4 people had received medical advice or treatment from a PA within two years of being surveyed. *Id.* More than 90% of these subjects reported satisfaction with the care they received. *Id.*

238. *Id.*

239. Roderick S. Hooker et al. *Patient Satisfaction with Physician Assistant, Nurse Practitioner, and Physician Care: A National Survey of Medicare Beneficiaries*, 12 J. SCI. COMM. CLINICAL OUTCOMES MGMT 88, 91 (2005).

240. *See* Roderick S. Hooker, et al. *Patient Satisfaction: Comparing Physician Assistants, Nurse Practitioners, and Physicians,* 1 *Permanente J. 38,* 38 (1997); D.J. Cipher et al., *Are Older Patients Satisfied With Physician Assistants and Nurse Practitioners?*, 19 J. AM. ACAD. PHYSICIAN ASSISTANTS, 36, 36-44 (2006).

vices since the integration of PAs into clinical practice.[241] In fact, studies have shown that a large proportion of patients who have not previously been seen by a PA report a willingness to accept healthcare services delivered by PAs.[242] This figure subsequently rose to ninety-five percent among patients surveyed after having received care from a PA.[243]

Outcome of care also measures quality of healthcare.[244] In a study of Air Force primary care clinics, the RAND Corporation assessed the experience of a decrease in physicians available for ambulatory care services.[245] In response, Air Force primary care clinics employed increased numbers of PAs and NPs to care for service members and their families.[246] To determine whether the providers compromised care, the study assessed the quality of the providers' care on the basis of responses to predetermined diagnostic, therapeutic and disposition criteria.[247] PAs performed as well as or better than physicians in identifying desirable therapeutic actions in five out of six of the evaluated therapeutic criteria.[248]

PA productivity similarly factors into quality of care, as documented in an analysis of the state of Utah.[249] Although PAs make up only 6.3% of Utah's combined clinician workforce (physician, PA, NP), they account for approximately 7.2% of the patient care in the state.[250] Nearly three-quarters of Utah's PAs work at least thirty-six hours per week, spending a greater percentage of total hours working in patient care than physicians.[251]

Data on primary care physician office encounters in the late 1990s shows that approximately one-quarter of office-based primary care physicians used PAs and/or NPs.[252] The study analyzed characteristics of patients and found

241. D.J. Cipher, *supra* note 240 at 36-44.

242. Roderick S. Hooker, et al. *Patient Satisfaction: Comparing Physician Assistants, Nurse Practitioners, and Physicians,* 1 *Permanente J.* 38, 38 (1997); Dorothy Budzi, *Veterans' Perceptions of Care by Nurse Practitioners, Physician Assistants, and Physicians: A Comparison from Satisfaction Surveys*, 22 J. Am. Acad. Nurse Practitioners 170, 170-76 (2010).

243. ASS'N OF ACADEMIC HEALTH CTRS,. THE ROLES OF PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS IN PRIMARY CARE 51-57 (D. Kay Clawson & Marian Osterweis eds., 1995).

244. Donabedian, *supra* note 232, at 692-93.

245. *See generally* GEORGE A. GOLDBERG & DAVID G. JOLLY, QUALITY OF CARE PROVIDED BY PHYSICIAN'S EXTENDERS IN AIR FORCE PRIMARY MEDICINE CLINICS (Rand 1980).

246. *Id.* at 1.

247. *Id.* at 34.

248. *Id*. (discussing the therapeutic criteria evaluated, which included desirable and undesirable actions on the part of the healthcare provider).

249. *See* D.M. Pedersen et al., *The Productivity of PAs, APRNs, and Physicians in Utah*, 21 J. AM. ACAD. PHYSICIAN ASSISTANTS, 1 42, 42–47 (2008).

250. *Id.*

251. *Id.*

252. Roderick S. Hooker & Linda F. McCaig, *Use of Physician Assistants and Nurse*

that the mean age of patients seen by physicians was greater than that for PAs or NPs.[253] The study also found that NPs provided counseling/education during a higher proportion of visits than did PAs or physicians.[254] The authors suggest that PAs and NPs are providing primary care in a way that is similar to physician care.[255] During the study period (1995-1999), the proportion of patients who saw a PA or NP rose from 30.6% to 36.1%.[256] Other researchers compared the quality of clinical care performance of PAs to that provided by their employing or supervising physicians.[257] The study revealed that the patient care management decisions made by PAs regarding certain morbidities were as good as, or better than, those decisions made by physicians.[258]

The effectiveness of health care delivery is contingent on the proper integration and mix of health care personnel.[259] In many settings, it is neither necessary nor efficient for each patient to be seen by a physician.[260] PAs are team-practice clinicians; the very nature of their clinical role is to work with physicians in a collaborative process.[261] An effective PA provides care comparable in quality to that of a physician.[262]

Various studies have evaluated the relationship between the type of provider and the attainment of treatment goals for diabetes, dyslipidaemia, and hypertension.[263] The VA Connecticut Health Care System conducted a cross-sectional analysis of 19,660 patients with diabetes, coronary artery disease, or hypertension.[264] While significant differences were noted in the types of patients cared for by PA/NPs and resident physicians, attainment of goals for each condition was similar, with one exception— PA/NP patients were more likely than the patients of resident physicians to attain an

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Practitioners in Primary Care 1995-1999, 20 HEALTH AFF. 231, 231 (2001).

253. *Id.*

254. *Id.*

255. *Id.* at 236.

256. Benjamin G. Druss et al., *Trends in Care by Nonphysician Clinicians in the United States*, 348 NEW ENG. J. MED. 130, 130 (2003).

257. Robert L. Kane et al., *Differences in the Outcomes of Acute Episodes of Care Provided by Various Types of Family Practitioners*, 6 J. FAM. PRACTICE 133, 135 (1978).

258. *Id.*

259. Roderick S. Hooker & Christine M. Everett, *The Contributions of Physician Assistants in Primary Care Systems,* 20 HEALTH & SOC. CARE IN THE COMMUNITY. 20, 25 (2012).

260. *Id.*

261. *Id.*

262. *Id.*

263. George L. Jackson et al., *Employment of Mid-level Providers in Primary Care and Control of Diabetes*, 5 PRIMARY CARE DIABETES, 25, 25 (2011); Pamela A. Ohman-Strickland et al., *Quality of Diabetes Care in Family Medicine Practices: Influence of Nurse Practitioners and Physician's Assistants*, 6 ANNALS OF FAM. MED., 14, 14 (2008).

264. Daniel G. Federman et al., *Relationship Between Provider Type and the Attainment of Treatment Goals in Primary Care*, 11 AM. J. OF MANAGED CARE, 561, 561 (2005).

HgbA1c goal of less than 7.5.[265]

Quality of care is dependent on access to care.[266] This notion is evident in emergency medicine ("EM"), where patients must be seen quickly and effectively.[267] A 2009 study showed that PA or NP involvement in the care of EM patients significantly reduced the wait times, lengths of stay, and proportion of patients who left without being seen.[268] Furthermore, at least one study demonstrated that, a significant benefit of a PA visit as compared to a physician visit is that the cost incurred from a PA visit is less than that of a physician visit in the same setting, such as an emergency room.[269]

Provider skill is paramount to quality of care.[270] Using a prospectively collected database of patients undergoing cardiac catheterization, the outcomes of procedures performed by PAs were compared with those performed by cardiology physician fellows-in-training.[271] Class 3 and 4 heart failure was more common in patients who underwent procedures by fellows compared with those undergoing procedures by PAs.[272] PA cases tended to be slightly faster with less fluoroscopic time.[273] The incidence of major complications within twenty-four hours of the procedure was similar between the two groups.[274] The study demonstrates that trained and experienced PAs can perform diagnostic cardiac catheterization with very low complication rates—similar to those of cardiology fellows-in-training.[275] Other procedural studies that involve high skill include colorectal cancer screening using flexible sigmoidoscopies.[276] The Horton study analyzed

265. *Id.* (This means that PA and/or NP care results in better management of patients with diabetes as lower HGBA1c is a marker for blood sugar control.).

266. *See* James Ducharme et al., *The Impact on Patient Flow After The Integration of Nurse Practitioners and Physician Assistants In 6 Ontario Emergency Departments*, 11 CAN. J. OF EMERGENCY. MED. CARE 455, 456 (2009) ("Delays in assessment and care may have negative effects on patient care and outcomes.").

267. *Id.*

268. *Id.* at 458 ("[W]hen a PA was involved in patient care the odds of the patient being seen within the benchmark wait time was 1.6 times greater than when the PA was not involved. . . . When the NP was involved, the odds were 2.1 times greater.").

269. Diana Dryer Wright et al., *Costs and Outcomes for Different Primary Care Providers*, 238 J. AM. MED. ASS'N 46, 46-50 (1977).

270. *See* Avedis Donabedian, *The Quality of Care: How Can it be Assessed?,* 260 J. AM. MED. ASS'N, 1743, 1743 (1988) ("[T]here are two elements in the performance of practitioners: one technical and the other interpersonal.").

271. Richard A. Krasuski et al., *Trained and Supervised Physician Assistants Can Safely Perform Diagnostic Cardiac Catheterization With Coronary Angiography*, 59 CATHETERIZATION & CARDIOVASCULAR INTERVENTIONS 157, 158 (2003).

272. *Id.* at 158-59.

273. *Id.* at 159.

274. *Id.*

275. *Id.* at 160.

276. *See generally* Leah B. Sansbury et al., *Physicians' Use of Nonphysician Healthcare Providers for Colorectal Cancer Screening*, 25 AM. J. OF PREVENTIVE MED., 179, 179-86 (2003); Kimberlee Horton et al., *Training of Nurse Practitioners and Physician As-*

data from 9,500 screening procedures.[277] The results from the screenings revealed that PAs and NPs possess the skills necessary to perform this procedure and thus increase the availability and lower the cost of flexible sigmoidoscopy for colorectal cancer screening.[278]

C. PAs – Low Risk, High Reward

The National Practitioner Data Bank ("NPDB") is a federal data bank that serves as a repository of all state board actions or malpractice actions against physicians, dentists, PAs, NPs, and other licensed healthcare professionals.[279] In 1987, the Medicare and Medicaid Patient and Program Protection Act introduced the concept of the NPDB to serve as a repository of information about the health care providers in the United States.[280] The NPDB was designed to protect Medicare and Medicaid beneficiaries from incompetent health care providers by restricting the ability of unfit practitioners from moving from state to state.[281] In 1990, the U.S. Department of Health and Human Services ("HHS") implemented the NPDB, which requires the "reporting of adverse licensure, hospital privilege, and professional society actions against physicians and dentists related to quality of care."[282] In 2007, the Health Resources and Services Administration proposed rules to add other practitioners and PAs to the NPDB.[283]

All healthcare practitioners applying for privileges to a hospital or medical center must provide in-depth personal and professional background information that is then submitted to NPDB for clearance.[284] Through this clearance process, from 1990 through 2008, the NPDB produced information on more than 414,000 reported board actions, malpractice payments, and Medicare/Medicaid exclusions that involved eighteen different types of providers.[285]

From 1991 to 2007, malpractice payments for all providers exceeded $74

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sistants to Perform Screening Flexible Sigmoidoscopy, 13 J. OF THE AM. ACAD. OF NURSE PRACTITIONERS, 455, 455 (2001).

277. Horton et al., *supra* note 276, at 457.

278. Horton et al., supra note 276, at 457. (The study here found that the availability of NAs and PAs in performing flexible sigmoidoscopies resulted in 33 percent lower costs than if the procedure was performed by a staff gastroenterologist).

279. *National Practitioners Data Bank*, NCSBN.ORG, *available at* https://www.ncsbn.org/418.htm (last visited Nov. 15, 2014); Lisa A. Miller, *The National Practitioner Data Bank: A Primer for Clinicians*, 25 J. OF PERINATAL & NEONATAL NURSING 224, 224 (2011).

280. NCSBN, *supra* note 302.

281. Miller, *supra* note 302 at 224.

282. NSCBN, *supra* note 302.

283. *Id.*

284. Miller, *supra* note 302 at 224.

285. Roderick S. Hooker et al., *Does the Employment of Physician Assistants and Nurse Practitioners Increase Liability?* 95 J. OF MED. LICENSURE & DISCIPLINE 6, 7 (2009).

billion.[286] Payments made for the malpractice of PAs and advanced practice nurses were less than .01 percent of the total payment made during that period.[287] The analysis suggests the rate and amount of malpractice payments for PAs is low compared with that for physicians. In fact, the NPDB data reveal one claim per eight practicing physicians versus one claim per 107 PAs.[288] These findings suggest that PAs may pose a low risk of malpractice liability to the public in general and to employing practices in particular.[289] Even taking into account the agency relationship that exists between PAs and physicians, one in-depth study found that physicians are still implicated in a far greater percentage of malpractice suits and claims than PAs.[290] In fact, the study found that a great level of physician supervision or involvement does not guard against malpractice claims.[291] However, the study determined that PA-physician teams were much less likely to face malpractice claims and suits than physicians practicing without PAs.[292]

Quality care research generally supports a broad scope of practice for PAs. Studies document high patient acceptance, quality, productivity, access, and skill for PA-provided care. PAs provide access to care in all fields of medicine, and their availability to meet the demands of more complex patient types means their adaptability to the standards of quality of care will be an important part of meeting workforce needs.

V. THE CHANGING SCOPE OF PRACTICE FOR PAS IN A CHANGING HEALTHCARE SYSTEM

The United States is facing an imminent deficiency of primary care pro-

286. *Id.* at 7-9 (To provide annual information on how three different types of providers were reported to the NPDB for adverse outcomes, fraud, misappropriation of professional role, and other actions, seventeen years of data involving 324,285 practitioners (physicians, PAs, and advanced practice nurses ("APN")) were analyzed. APNs are NPs, certified nurse specialists ("CNS"), certified nurse midwives ("CNM"), and certified registered nurse anesthetists ("CRNA").

287. *Id.* at 9. ("PA payments comprised just 0.003 percent of the total; APN payments comprised only 0.007 percent of the total." Mean and median payments, for each provider were: APNs at $350,540 and $190,898; physicians at $301,150 and $150,821; PAs at $173,128 and $80,003. The adjusted mean payment for doctors was 1.7 times higher than PAs and 0.9 that of APNs. The adjusted median payment for doctors was 1.9 times that of PAs and 0.8 that of APNs. Among providers, the APN adjusted mean payments were 2.0 times that of PAs, and median payments were 2.4 times that of PAs.").

288. *Id.* at 10.

289. *Id.*

290. Matt Ledges et al., *Physician Assistants and Your Risk of Malpractice: Case Study Examines Your Litigation Risks – and the Findings May Surprise You,* Med. Econ. (Oct. 10, 2011), http://medicaleconomics.modernmedicine.com/medical-economics/news/modernmedicine/modern-medicine-feature-articles/physician-assistants-and-your?page=full.

291. *Id.*

292. *Id.*

viders.[293]

Some researchers predict a shortage of 35,000-44,000 primary care physicians by 2025.[294] The Association of American Medical Colleages predicts a far more dire scenario: a shortage of approximately 45,000 primary care physicians by 2020, increasing to approximately 66,000 by 2025.[295]

As these projections persist, and as a surge of newly insured patients continue to enroll with implementation of the ACA, discussions and debates continue over how to ensure that patients have adequate access to care.[296] The ACA addressed this by promoting patient-focused, access to team-based care through encouraging the development of new models of care, including Patient Centered Medical Homes ("PCMH") and Accountable Care Organizations ("ACOs").[297] These models set the stage for increased breadth and effectiveness of care coordination in the United States, and PAs

293. Karin Rush-Monroe, *UCSF Researchers Offer Solutions To Looming Health Care Provider Shortage*, UCSF NEWS (Nov. 5, 2013), *available at* http://www.ucsf.edu/news/2013/11/110081/ucsf-researchers-offer-solutions-looming-health-care-provider-shortage# ("The United States faces a severe shortage of primary health care providers, due to a wave of aging baby boomers, epidemics of diabetes and obesity and the Affordable Care Act, which aims to bring health care coverage to millions more Americans.").

294. Jack M. Colwill et al., *Will Generalist Physician Supply Meet Demands of an Increasing and Aging Population?* 27 HEALTH AFF. 232, 236 (2008).

295. *The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025*, ASS'N OF AM. MED. COLL., *available at* https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf (last visited October 2, 2014). *See also, Physician Shortages to Worsen Without Increases in Residency Training*, ASS'N OF AM. MED. COLL., *available at* https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf (last visited Nov. 11, 2014) (further predicting greater shortages due to funding constraints on postgraduate training for residents and fellows).

296. News Release, Coalition for Patients' Rights, Meeting Primary Care Needs of Patients Drives Debate, Discussion on Workforce Shortage (March 27, 2013), *available at* http://www.patientsrightscoalition.org/Media-Resources/News-Releases/wrkfcshrtg.aspx.

297. *See* Valerie Blake, *Scope of Practice in Team-Based Care: Virginia and Nationwide,* 15 VIRTUAL MENTOR AM. MED. ASS'N. J. OF ETHICS, 518, 518 -521 (2013) In order to control health care costs and increase care coordination, proposals to reform U.S. health care delivery and payment emphasize team-based models of care. Accountable care organizations (ACOs) under the Affordable Care Act of 2012 (ACA) are one such example. In that model, groups of physicians, hospitals, and other providers join together to provide cost-conscious, quality, coordinated care to patients.*; See also* Karen Davis et al., *How the Affordable Care Act Will Strengthen the Nation's Primary Care Foundation*, 26 J. GEN. INTERN MED, 1201, 1202 (2011) The ACA also incentivizes the adoption of another model of care: the patient centered medical home. This is accomplished through increased reimbursement to primary care sites designated as "health homes" for Medicaid patients with chronic conditions. While health homes are similar to medical homes, they place more emphasis on public health integration and the potential lead role of advanced practice nurses. Under the ACA, teams of primary care providers—physicians, PAs, and nurse practitioners—provide comprehensive care management, care coordination health promotion, transitional care between hospital and primary care, referral to community and social services, patient and family engagement and use of information technology to link services.

have a vital role to play in both of these new models of care.[298]

In the late 1960s, the American Academy of Pediatrics ("AAP") introduced the concept of a "medical home" as a way to improve the care of children with special needs.[299] Originally, the term was used to characterize a central repository for archiving medical information about this population of pediatric patients.[300] In 2007, the American Academy of Family Physicians ("AAFP"), the American College of Physicians ("ACP"), AAP, and the American Osteopathic Association ("AOA") jointly determined that the term "medical home" had evolved to encompass an approach to primary healthcare that is coordinated, comprehensive, integrated, patient-centered, accessible, high quality and safe: the PCMH.[301] According to the Institute of Medicine, patient centeredness is health care with a foundation in the partnership between the providers and their patients.[302] Patients are involved in every step of the process.[303] PAs have the knowledge and skills that are needed to provide patient-centered care and build and preserve an effective PCMH because of the team approach nature of the PA education, regulation, and clinical style.[304] In fact, the profession aligns with the PCMH model since PA practice is integrated, patient-focused, and team-based.[305] As adept clinicians, exceptional communicators, and talented team players,

298. *See* Stephen H. Hanson, *Physician Assistants: Recognized, Valued in Healthcare Reform*, PHYSICIANS PRACTICE BLOG (Aug. 31, 2012), *available at* http://www.physicianspractice.com/blog/physician-assistants-recognized-valued-healthcare-reform ("[T]he ACA fully integrates PAs into newly established models of coordinated care. PAs play an important role in patient-centered, primary-care medical homes, Independence at Home models of care, chronic care management, and other new models of care designed to better coordinate care through team-based practice and to promote value to the healthcare delivery system.").

299. Calvin Sia et al., *History of the Medical Home Concept*, 113 J. OF THE AM. ACAD. OF PEDIATRICS 1473, 1473 (2004).

300. ROBERT GRAHAM CTR., *The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational* Change 1, 4 (2007).

301. PATIENT CENTERED PRIMARY CARE COLLABORATIVE, JOINT PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME 2 (2007), *available at* http://www.pcpcc.org/about/medical-home.

302. Margarita P. Hurtado et al., INST. OF MEDICINE, ENVISIONING A NATIONAL HEALTH CARE QUALITY REPORT (2001).

303. *Id.*

304. AM. ACAD. OF PHYSICIAN ASSISTANTS, PROFESSIONAL ISSUES: ISSUE BRIEF: PHYSICIAN ASSISTANTS AND THE PATIENT-CENTERED MEDICAL HOME 1 (2013), *available at* http://www.aapa.org/WorkArea/DownloadAsset.aspx?id=581 ("PAs, as skilled medical providers, excellent communicators and consummate team players, embody qualities essential to an effective PCMH practice . . . Understanding team dynamics is one of the major challenges to creating a successful medical home. With their education, regulation and clinical style all based on a team approach to care, PAs bring to a practice a finely tuned understanding of the skills required to create and sustain an effective PCMH practice.").

305. ISSUE BRIEF, *supra* note 304, at 1.

PAs exemplify fundamental qualities of an effective PCMH practice.[306]

While it is readily acknowledged that harmonized care delivered by multidisciplinary partners is a hallmark of the PCMH, there are differing opinions on which health care professionals should be included on and lead the team.[307] Doctor Kevin Bernstein, a family medicine resident in a Level 3 PCMH[308] and co-founder of Future of Family Medicine, summarized how the medical home he practices in functions, stating:

> Our medical home has a team leader. At any time it can be a nurse, a physician or whoever is available to take charge and make sure our patients are cared for. This is the point. Whether or not it needs to be a physician or a nurse practitioner, the evidence is lacking . . . All I know is, from my n=1 experience, physicians and nurse practitioners, as well as the many other people involved with our patients, all need to work in collaboration to provide better, more advanced and evidence-based primary care. Independent practice by physicians with limited staff does not support this. You can go to battle to defend your turf, your ego, or whatever else may get in the way of your patients. My medical home team is going

306. *Id.* at 3.

307. Holly Korda, *Where's the Patient In the Patient-Centered Medical Home?* HEALTH AFF. BLOG (Apr. 26, 2011), *available at* http://healthaffairs.org/blog/2011/04/26/where%E2%80%99s-the-patient-in-the-patient-centered-medical-home/ ("While the PCMH opens the door to bring new players and professional disciplines to the patient care team, the division of labor and responsibility has been a source of considerable angst, often pitting professional groups at odds over who is in charge. Physicians may assume dominion as primary care team leaders, but nurse leaders, in particular, have been fast to question this role.").

308. Kevin Bernstein, *Who Should Lead the Patient Centered Medical Home?*, KEVINMD.COM BLOG (Dec. 2, 2012), http://www.kevinmd.com/blog/2012/12/lead-patient-centered-medical-home.html; NATIONAL COMM'N FOR QUALITY ASSURANCE, STANDARDS AND GUIDELINES FOR NCQA'S PATIENT-CENTERED MEDICAL HOME (PCMH) 2014 (2014) (The NCQA recognizes PCMHs. The NCQA PCMH Recognition program is a practice-based evaluation for clinicians who provide care in primary care specialties. The program evaluates primary care provided to all patients in the practice. Recognition status lasts for three years and must be renewed in order to be maintained. In order to earn NCQA Recognition, practices must meet rigorous standards for addressing patient needs for example, offering access after office hours and online so patients get care and advice, where and when they need it. There are six PCMH standards, with one overall score. Each standard is composed of specific elements. Standards evaluate a practice's ability to function as a patient-centered medical home. The six PCMH standards for 2014 are: Enhance Access and Continuity, Team-Based Care, Population Health Management Care Management and Support, Care Coordination and Care Transitions and Performance Measurement and Quality Improvement. There are three levels of NCQA PCMH Recognition; each level reflects the degree to which a practice meets the requirements of the elements and factors that comprise the standards. For each element's requirements, NCQA provides examples and requires specific documentation. The NCQA Recognition levels allow practices with a range of capabilities and sophistication to meet the standards' requirements successfully. The point allocation for the three levels is as follows. Level 1: 35–59 points and all 6 must-pass elements. Level 2: 60–84 points and all 6 must-pass elements. Level 3: 85–100 points and all 6 must-pass elements. Level 3 Recognition is the highest that a practice may achieve).

> to go to battle for our patients. With my n=1 experience, I am proud to say that this is worth fighting for. So, who is the leader in the patient centered medical home? The answer is easy: our patients. And they deserve increased access to a team of providers.[309]

The reality, however, is that the apportionment of medical services and accountability within the PCMH model has been the root of substantial anxiety, often resulting in conflicting views among professional groups about who is in charge and often losing sight of the patient entirely.[310] This stems from the adamant insistence by organizations like the AMA and AAFP that PCMHs conform to physician-led organized medicine.[311] Although these and the other founding organizations of the PCMH concept assert that physicians should singularly lead the patient care, the organizations that offer PCMH recognition or accreditation recognize PAs as primary care providers who are qualified to lead patient care teams.[312] The rationale is simple: leading a PCMH and receiving clinical guidance from a physician are not mutually exclusive concepts. [313] PAs routinely perform medical acts and

309. Bernstein, *supra* note 308.

310. Korda, *supra* note 307.

311. Letter from James L. Madara, MD, Executive Vice President, CEO, American Medical Association to Mark R. Chassin, MD, FACP, MPP, MPH, President, The Joint Commission (Apr. 12, 2013) (on file with the author) ("We support the proposed revisions that would align the certification requirements with Stage 2 meaningful use criteria but remain concerned that the revised requirements do not fully recognize the critical role of physician (MD/DO) leadership/oversight of the medical home. We have the utmost confidence in the ability of non-physician practitioners to safely perform specified patient care activities under appropriate physician supervision, as occurs daily in many of our practices. However, non-physician practitioners do not have the knowledge and experience to safely, consistently, and independently carry out the tasks demanded of the leaders of medical homes ("primary care clinicians"), including, for example, directing patient care and reconciling medications for patients with complex pharmacological needs. We would note in particular that non-physician practitioners such as advanced practice nurses and physician assistants are not qualified to independently resolve conflicting recommendations for care, as is explicitly required of them under The Joint Commission's glossary definition of primary care clinician. It is for this reason that the 'Joint Principles of the Patient-Centered Medical Home,' which were developed by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association, and endorsed by the AMA, assert that each patient should have ongoing relationship with a personal physician (MD/DO) who should lead the medical home interdisciplinary team and assume ultimate accountability for patient care."); AM. ACAD. OF FAMILY PHYSICIANS, PRIMARY CARE FOR THE 21ST CENTURY: ENSURING A QUALITY, PHYSICIAN-LED TEAM FOR EVERY PATIENT 6 (2012) ("Leadership is required in a medical home just as it is required in businesses, governments, schools, athletics, and other organizations. Just as every American should have a primary care doctor, every medical home must have a physician serving as a leader who brings the highest level of training and preparation to guide the integrated, multidisciplinary team.").

312. ISSUE BRIEF, *supra* note 304.

313. AM. ACAD. OF PHYSICIAN ASSISTANTS, 2013-2014 POLICY MANUAL, 1, 75 (2013); ISSUE BRIEF, *supra* note 304, at 3-4.

procedures according to delegated autonomy, and the manner and degree of physician oversight is adjusted to accommodate the needs of a respective practice and its patients.[314]

The evolution in furtherance of modernizing and reinforcing primary care delivery systems gives PAs an important opportunity to set the pace for innovation.[315] PAs are taking advantage of this opportunity, playing significant roles in transforming their practices to the PCMH model.[316] A PA at TransforMED, a not-for-profit advisory program conceived by the AAFP to advance and aid practices wishing to implement the PCMH model, has committed to rallying and teaching team-building as family practices endeavor to develop into medical homes.[317] Initial data analysis from TransforMED indicated that when it instructed teams to exchange information and ideas more effectively, and when providers were given the tools and resources necessary to utilize their team in a more significant way, the quality of life of the providers increased.[318] The team-based care concept is also inherent in Washington State at Group Health Cooperative—a massive system that coordinates care and coverage.[319] Within this healthcare network, a PA practices medicine with several physicians and another PA while simultaneously serving as the medical chief of the Redmond Medical Center.[320] Although the patient panels are within the sole purview of the physicians, the PAs regularly facilitate their management.[321] The PA also oversees elderly patients, who often have intricate and complicated medical issues.[322] Group Health also takes advantage of the many technological advances that have been made in recent years as part of its patient-centered approach.[323] Each interaction with a patient is called a "touch" and modern telephone automation allows patients to link precisely to their primary care providers by keying in their medical history number.[324]

Another example of PA leadership within the PCMH model of care is found in the medical home criterion of timely access to care, including

314. *See* ISSUE BRIEF, *supra* note 304, at 2, 4.

315. *See* Leslie Kole, *Transforming Primary Care: PAs and Patient-centered Medical Homes*, PA PROF., 20, 21 (Oct. 2012) ("The PA profession has been firmly rooted in providing primary care since its inception. The movement toward redesigning and strengthening primary care delivery systems gives PAs tremendous opportunities to be leaders in innovation.").

316. *Id.*

317. *Id.* at 22.

318. *Id.*

319. *Id.* at 23.

320. *Id.*

321. *Id.*

322. *Id.*

323. *Id.* at 25.

324. *Id.*

medical appointments outside of traditional office hours, particularly during evenings and weekends.[325] PAs have been essential in broadening that access.[326] For example, a PA in Maryland joined Johns Hopkins Community Physicians to assist in the implementation of a PCMH pilot at the Water's Edge clinic to increase the availability of same-day appointments.[327] Because of prior experience in urgent care and emergency medicine, this PA was an ideal match for the clinic's needs.[328]

Ultimately, full utilization of PAs in PCMHs will require a cultural shift that allows for the most qualified health professional to lead the metamorphosis of a practice.[329] This will only be achieved when organized medicine fully understands and embraces the concept that such leadership does not preempt physician leadership in many aspects of clinical medicine.[330] The PCMH is intended to advance and enhance the coordination of care among clinicians, while ACOs have the far-reaching goal of coordinating care across the complete spectrum of healthcare, from physicians to facilities to other clinicians.[331] PCMHs and ACOs are undeniably intertwined.[332] PCMHs are the core of ACOs, which provide the foundation for a team approach to healthcare delivery systems.[333]

The concept of an "accountable care organization" originally described arrangements committed to quality and efficiency with the goal and the power to impose practice, reporting, and compensation standards across a group of providers on behalf of the patient population.[334] An ACO is defined as "a group of healthcare providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get."[335] An ACO's payment is "tied to achieving healthcare quality goals

325. *Id.* at 24.

326. *Id.*

327. *Id.*

328. *Id.*

329. *See* ISSUE BRIEF, *supra* note 304 at 4.

330. *Id.*

331. David L. Longworth, *Accountable Care Organizations, the Patient-Centered Medical Home, and Health Care Reform: What Does It All Mean?* 78 CLEVELAND CLINIC J. MED. 571, 577 (2011), *available at* http://www.ccjm.org/content/78/9/571.long.

332. *Id.* at 571.

333. *Id.*

334. Stephen M. Shortell & Lawrence P. Casalino, *Health Care Reform Requires Accountable Care Systems,* 300 J. AM. MED. SOC'Y. 95, 95 (2008); *see also* Elliott S. Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. 219, 219 (2009) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2656392/; STEPHEN M. Shortell et al., BERKLEY CTR. ON HEALTH ECON. & FAMILY SEC., IMPLEMENTING ACCOUNTABLE CARE ORGANIZATIONS ii (2010).

335. *Glossary: Accountable Care Organization,* HEALTHCARE.GOV, *available at* https://www.healthcare.gov/glossary/accountable-care-organization/ (last visited Nov. 16, 2014.).

and outcomes that result in cost savings."[336] HHS rules governing Medicare ACOs[337] detail the standards and specifications for ACOs with the objective of incentivizing stakeholders to deliver comprehensive, improved quality care to Medicare beneficiaries while reducing expenditures.[338] ACOs are formulating, organizing, and exploring various approaches to adjust reimbursement in primary care and to incentivize advancements in effectiveness, capacity, and care management.[339] Numerous productive ACO configurations are adopting a departure from quantity-based reimbursement to quality-based reimbursement, and the development of population health management centers.[340]

Ideally, PAs would have received beneficiary assignments; however, the Centers for Medicare and Medicaid Services did not modify its standards and therefore this remains within the sole purview of physicians.[341] The final rules allow patients who are cared for in certified rural health clinics and federally qualified health centers, many of which are staffed by PAs, to enroll in ACOs.[342] Additionally, the PA's role as an ACO professional was preserved allowing for the complete participation of patients being treated in certified Rural Health Clinics.[343] Patients treated chiefly by PAs could be counted toward the 5,000-patient count required to set up an ACO.[344] A portion of provisions within the ultimate regulation may support the incorporation of patients who do not personally receive care from a physician.[345] While it is anticipated that a clarification of the final language will fully include PA-provided patient care, such an interpretation is uncertain.[346] Nev-

336. *Id.*

337. Press Release, Ctrs. for Medicare & Medicaid Servs., *HHS Announces New Incentives for Providers to Work Through Accountable Care Organizations* (Oct. 20, 2011), *available at* http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2011-Press-Releases-Items/2011-10-20.html.

338. Michael Powe, *Final ACO Rules Released*, PA PRO NOW BLOG (October 26, 2011, 4:45 PM), *available at* http://www.aapa.org/news_and_publications/pa_pro_now/item.aspx?id=3085&terms=Final%20ACO%20Rules%20Released.

339. Kole, *supra* note 315, at 21.

340. *Id.*

341. *See* Powe, *supra* note 338.

342. Michelle Perron Pronsati, *Final ACO Rules a Mixed Bag for NPs & PAs,* ADVANCE HEALTHCARE NETWORK (Dec. 1, 2011), *available at* http://nurse-practitioners-and-physician-assistants.advanceweb.com/News/Front-Center/Final-ACO-Rules-a-Mixed-Bag-for-NPs-PAs.aspx.

343. *See id.*

344. *Id.*

345. *Id.*

346. *Id.* Michael Powe, Vice President for Reimbursement and Professional Advocacy at the AAPA, said there is a bright spot in language that may allow the inclusion of patients who do not receive care directly from a physician. "AAPA staff will work with [CMS] in an attempt to obtain an interpretation of the final language that will fully include PAs treating as part of the physician-PA team."

ertheless, PAs are embracing clinical leadership within both PCMHs and ACOs.[347] For example, a chief PA with Southern California's OptumHealth collaborates with a medical director to teach clinicians about the various plans and programs that ACO participants may use.[348] This PA also facilitates the administration and oversight of OptumHealth's "Welcome to Medicare" program.[349] This specific ACO program has resulted in enhanced patient care due to increased access to data and care integration.[350]

PAs have proven their capacity to skillfully tailor medical exams to the advantage of the individual patient.[351] Since patient information prepopulates the electronic medical record, yearly wellness visits are exceptionally organized and PAs can devote time and attention to quality benchmarks such as blood pressure control, Body Mass Index, and colonoscopies.[352] Within the ACO's integrated structure, PAs have the means and resources to decipher and analyze a patient's billing data and medical records, which incorporate details from other provider visits and any diagnostic studies or x-rays that have been conducted.[353] When compared to the care provided to a traditional fee-for-service Medicare patient, the PA skill set affords an opportunity for enhanced patient follow up and continued care coordination.[354]

Steward Health Care, a forward-looking ACO in New England and the second largest healthcare system in that region, utilizes PAs at every level of its organization.[355] A PA at this location is a director of performance and bridges the knowledge disparities between policy makers and healthcare providers within Steward's healthcare network.[356] As an innovative ACO, "Steward is responsible for a large at-risk population."[357] The network is held accountable for quality metrics and remunerated accordingly through contracts with Blue Cross Blue Shield.[358] ACOs calculate success on outcomes, and Steward is deeply engrossed in coordinating care for patients

347. *See* Beth Grivett, *Embracing Clinical Leadership in an Accountable Care Organization*, PA BLOG (Nov. 20, 2013), *available at* http://www.pasconnect.org/embracing-clincial-leadership-in-an-accountable-care-organization/.

348. *Id.*

349. *Id.*

350. *Id.*

351. *Id.* Patients have responded well when PAs are involved in their preventative care. As a result, the patients' annual check-ups are managed better because electronic records are already available to the PA and all they need to focus on is quality care measures.

352. *Id.*

353. *Id.*

354. *Id.*

355. Heather Trafton, *Business-Minded PA Ideally Suited for ACO*, PA BLOG (Nov. 20, 2013), *available at* http://www.pasconnect.org/business-minded-pa-ideally-suited-for-aco/.

356. *Id.*

357. *Id.*

358. *Id.*

with chronic diseases and multiple comorbidities.[359] Overall patient health has an increased likelihood for improvement because the community care-based model that is utilized at Steward permits patient referral to local resources.[360] This decentralized concept satisfies the distinctive essence of the Steward network, which constitutes several modest practices spread over 150 communities, versus a consolidated system on one centralized campus.[361] PAs in Steward also engage in group-based patient visits to meet patient needs.[362]

In addition to health system changes, technologic developments are impacting PA scope of practice.[363] A key example is the advent and expansion of telemedicine, which is the transmission of medical information through various methods in order to improve a patient's health.[364] With roots dating back more than forty years to demonstrations of hospitals delivering care to patients in remote areas, the use of telemedicine has expanded rapidly and is primed for synthesis into the continuous activities of hospitals, home health agencies, and private physician offices.[365] Not to be considered as a distinct and separate medical specialty, telemedicine simply serves as a complement to the way in which medicine is practiced—a tool for providers.[366] Devices and services associated with telemedicine are usually just one component of a more substantial investment by healthcare institutions in clinical care delivery or information technology.[367]

States are increasingly recognizing the importance of PAs in telemedicine.[368] For example, in 2010 Texas implemented regulations to include PAs as both distance and on-site telemedicine providers.[369] Kentucky also saw improvements to embrace emerging technology and telemedicine when, in 2013, the Kentucky Board of Medical Licensure updated its defi-

359. *Id.*

360. *Id.*

361. *Id.*

362. *Id.*

363. *See* Stephen H. Hanson, *Technology Can Extend the Physician Assistant's Role in Patient Care*, PHYSICIANS PRACTICE BLOG (Jan. 4, 2013), http://www.physicianspractice.com/blog/technology-can-extend-physician-assistants-role-patient-care (Stating that advances in technology have created HIPAA issues in physician offices when it comes to physician supervision of staff, especially given the widespread human resource problem in healthcare).

364. *What is Telemedicine*?, AM. TELEMEDICINE ASS'N, http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VCCF9fldWSo (last visited Nov. 16, 2014).

365. *Id.*

366. *Id.*

367. *Id.*

368. *See* 22 TEX. ADMIN. CODE §§ 174.1-174.12 (2010) (implementing rules to regulate the provision of telemedicine within the state).

369. *Id.*

nition of "on-site" to allow PAs to practice medicine in a variety of settings as long as the physician with whom they practice can be contacted.[370] Currently, twenty-one states have parity laws that require private insurers to reimburse for telemedicine visits, and forty-four state Medicaid programs reimburse in some form for telemedicine.[371] However, no two state laws are alike and reimbursement policies vary wildly.[372] Medicare reimburses for telemedicine, but only for patients who live in a designated rural Health Professional Shortage Area or in a county outside of a Metropolitan Statistical Area.[373] Regarding PA practice specifically, Medicare clearly allows PAs to be distant site providers.[374]

Every state has law that authorizes physicians to provide supervision via telecommunication, and physician-PA teams currently interact using a wide variety of telecommunication modalities.[375] Telemedicine is an indispensable part of PA scope of practice and affords an essential and invaluable opportunity to care for patients, especially those in rural communities.[376] Some of the ways in which PAs accomplish this include: monitoring medications and the condition of patients with HIV and AIDS in isolated communities throughout the Southeast, conducting the initial assessments of children with autism throughout rural and central Pennsylvania as members of behavioral pediatrics teams, and working as both on-site providers and consultants who treat patients with psychiatric conditions and connect rural

370. *Kentucky Loosens Requirements on Physician Assistants,* NEPHROLOGY NEWS (March 21, 2013), http://www.nephrologynews.com/articles/109388-kentucky-loosens-requirements-on-physician-assistants.

371. Chris Mazzolini, *Telemedicine's Next Big Leap*, MED. ECON. 64, 66 (Oct. 25, 2013), *available at* http://medicaleconomics.modernmedicine.com/medical-economics/news/telemedicines-next-big-leap.

372. *Id.*

373. *Id.*

374. CTR. FOR MEDICARE AND MEDICAID SERVS., TELEHEALTH SERVICES RURAL HEALTH FACT SHEET SERIES 2 (2014), *available at* http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf.

375. NAT'L. GOVERNORS ASS'N., THE ROLE OF PHYSICIAN ASSISTANTS IN HEALTH CARE DELIVERY (2014), *available at* http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1409TheRoleOfPhysicianAssistants.pdf ("All states have laws and regulations that explicitly authorize physicians to supervise PAs through electronic communication."); *See specifically* MINN. STAT. ANN. § 147A.01 Subd. 24 (2014) (defining "supervision" to mean overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required so long as the supervising physician and physician assistant are or can be easily in contact with one another by radio, telephone, or other telecommunication device. The scope and nature of the supervision shall be defined by the individual physician-physician assistant delegation agreement).

376. AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, PHYSICIAN ASSISTANTS AND TELEMEDICINE: OPPORTUNITY FOR RURAL COMMUNITIES (2012) (on file with the author).

patients with psychiatric services located in a metropolitan area.[377] Another example of PAs taking an active role in the utilization of this technology is in the application of teledermatology, which utilizes "the remote delivery of dermatologic services and clinical information using telecommunications technology."[378] Two forms of teledermatology are commonly used. The first, called store-and-forward ("SAF"), uses asynchronous still digital image technology for communication, similar to e-mail.[379] In this approach, participants are typically separated by both time and space.[380] In the second, termed "real-time" or "live-interactive video-conferencing," audio-visual technology is used and participants are separated by space, but not by time.[381]

This application has become particularly important for patients in rural areas where even the most convenient and accessible dermatology practice may be in excess of hundreds of miles. This distance frequently results in treatment delays that can put patients at increased risk.[382] Geisinger Health System in Northeastern and Central Pennsylvania utilizes PAs in teledermatology so that rural patients in Pennsylvania can have better access to der-

377. *Id.*

378. *Teledermatology,* AM. ACAD. OF DERMATOLOGY, https://www.aad.org/members/practice-and-advocacy-resource-center/practice-arrangements-and-operations/teledermatology (last visited Nov. 16, 2014) (defining teledermatology). *See also* Sharon Rounds, *Innovative Approaches to Healthcare Delivery at the Providence VA Medical Center, 93* MED. & HEALTH R.I. 6, 6-7 (2010) (discussing PA utilization of teledermatology in the Dermatology Section of the Providence VA Medical Center and provision of teledermatology services to VA facilities in rural Maine.).

379. *Teledermatology,* AM. ACAD. OF DERMATOLOGY, https://www.aad.org/members/practice-and-advocacy-resource-center/practice-arrangements-and-operations/teledermatology (last visited Nov. 16, 2014); *See also* AM. TELEMEDICINE ASS'N., STATE MEDICAID BEST PRACTICE STORE-AND-FORWARD TELEMEDICINE (2013) ("Store-and-forward telemedicine refers to the use of asynchronous [not real-time] computer-based communication between a patient to a consulting provider [referred to as "Direct-to-Consumer"], or a referring healthcare provider and a medical specialist [referred to as "Provider-to-Provider"] at a distant site for the purpose of diagnostic and therapeutic assistance in the care of patients who otherwise have no timely access to specialty care. The use of asynchronous transmissions is common for some specialties such as radiology and pathology. However, other medical specialties such as dermatology and ophthalmology that can effectively and economically utilize store and forward telemedicine to improve patient access and quality of care are often not covered for Medicaid reimbursement.").

380. *Id.*

381. *Id.*

382. Karyn B. Stitzenberg et al, *Distance to Diagnosing Provider as a Measure of Access to Patients with Melanoma*, 143 ARCHIVES OF DERMATOLOGY 991, 997 (2007), *available at* http://archderm.jamanetwork.com/article.aspx?articleid=654325&resultClick=3. The farther that patients travel to reach their diagnosing providers, the more advanced their stage at diagnosis is likely to be. Although we do not yet have survival data, it is reasonable to surmise that differences in Breslow thickness at diagnosis could translate into differences in overall survival.

matological care.[383] Through practice sites located at Geisinger satellite clinics, which house full-time primary care providers and rotating specialists, PAs are able to take histories, perform examinations, and photograph every patient.[384] When needed, biopsies are performed.[385] Clinical photos accompany comprehensive notes that incorporate treatment plans that the PAs have already commenced—reflecting a SAF model.[386] By virtue of Geisinger's electronic medical record system, the PA's supervising physician is able to comment on the diagnoses and treatment plans, evaluate chart notes, affix attestations to chart notes, and view pictures on sizable high-definition computer screens in a workplace only one to two hours away from the PAs.[387] The physician also has the opportunity to confer on complex patients, assess the clinic's functionality, and attend to pertinent matters or particular issues through regularly scheduled appointments and site visits.[388]

A. Language Conventions and the PA Profession

While PAs are embracing new technologies and becoming valued providers in new models of care, some people argue that the expansion of PA scope of practice and the advancement of the profession is being hindered by two specific language conventions: the appropriate title of the profession, and the term "supervision."[389]

An abundance of names have been interchangeably used in both medical literature and the media with "physician assistant": midlevel provider, nonphysician provider, physician extender, allied health professional, healthcare practitioner, and advanced practice provider.[390] However, AAPA's policy affirms that "physician assistant" is the official title of the

383. Dan Wagener, *Bringing Dermatology to Underserved Areas with Telemedicine*, PA BLOG (Apr. 10, 2013), http://www.pasconnect.org/bringing-dermatology-to-underserved-areas-with-telemedicine/.

384. *Id.*

385. *Id.*

386. *Id.*

387. *Id.*

388. *Id.*

389. RUTH BALLWEG ET AL., *supra* note 14, 6-7 (3d ed. 2013) (regarding the title of the profession); *See also AFPPA Membership Supports PA Name Change from "Assistant" to "Associate,"* ASS'N FAM. PRAC. PHYSICIAN ASSISTANTS, http://www.afppa.org/index.php?option=com_content&view=article&id=130:afppa-membership-supports-pa-name-change-from-assistant-to-associate&catid=3:general-public&Itemid=11 (last visited Nov. 16, 2014) Some feel that the profession has outgrown the designation "assistant" and that a more appropriate designation is "associate." They assert that "assistant" has unfavorable implications and does not accurately reflect the role of the profession. They also argue that such a change is necessary in order to advance the profession and avoid confusion for patients who may mistake physician assistants for medical assistants.).

390. *Id.*

profession.[391] AAPA policy also provides that whenever feasible, PAs should be referred to as "physician assistants" and not included with other providers in comprehensive general terms such as "midlevel practitioner."[392] The official name of the profession has been fervently debated throughout its almost fifty year history.[393]

Proponents of changing the title of the profession would like to replace "assistant" with "associate."[394] Among other reasons, those in favor of the title change contend that such a modification is reasonable given that in the early days of the profession, some of the country's most prominent PA programs were "physician associate programs."[395] In an era where consumers and patients are demanding more transparency, proponents also contend that the title "assistant" is bewildering and deceptive.[396] Those in favor of a name change believe the current title virtually assures that "physician assistants" will be mistaken for "medical assistants," and lead patients to conclude that they are receiving lower-level care or that they will subsequently be evaluated by a physician.[397] Lastly, they cite the fact that as PAs are being asked to take on more responsibilities for patient care, their role has evolved into more than that of an "assistant."[398]

Alternatively, those who support leaving the title unchanged assert that there is increasing acceptance by the medical community of PAs, and that patients embrace PA-provided care irrespective of the name.[399] Further,

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391. *Id.*

392. *Id.*

393. *CardioVision, AAPA House of Delegates Report*, APACVS, (Summer/Fall 2012), *available at* http://apacvs.org/multimedia/files/journals/APACVS2012Summer-FallCardioVISION.pdf .

394. *See* Robert M. Blumm et al., *Physician Associate: A Change Whose Time Has Come*, ADVANCED HEALTHCARE NETWORK (April 12, 2010), http://nurse-practitioners-and-physician-assistants.advanceweb.com/Features/Article-4/Physician-Associate-A-Change-Whose-Time-Has-Come.aspx; *See AFPPA Membership Supports PA Name Change from "Assistant" to "Associate"*, *supra* note 389 (discussing the most recent debate over the official title of the profession in 2012).

395. *See* John A. Braun et al., *The Physician's Associate—A Task Analysis*, 63 AM. J. PUB. HEALTH 1024, 1024 (1973), *available at* http://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.63.12.1024 (citing Dr. Eugene A. Stead's, Jr's 1965 initiation at Duke University of the first formal physician's assistant program which was termed "physician's associate program.").

396. *AFPPA Membership Supports PA Name Change from "Assistant" to "Associate,"* *supra* note 389.

397. *Id.*

398. Letter from Ass'n of Physician Assistants in Cardiology to Fla. Ass'n of Physician Assistants, *available at* http://www.fapaonline.org/files/AAPANameChange.pdf.

399. John D. Trimbath, *Is Our Name Really the Issue?*, 7 J. AM. ACAD. PHYSICIAN ASSISTANTS 51, 51-2 (1994) ("Ironically, the nomenclature that was chosen for us represented very little toward gaining our professional recognition. It matter not what we were called, but how we were used. What played a major role in our success was the means by which we answered our call to provide cost-effective, high-quality health care services. And because

those in opposition to altering the name argue that such an endeavor is an intricate and expensive one, particularly for such a heavily regulated profession.[400] The work involved in achieving a title change could potentially undermine more important endeavors, such as improving educational opportunities for PAs, removing legal barriers to PA practice, and sponsoring philanthropic ventures.[401] Changing the title of the profession would require legislative and regulatory amendments at the federal state and territorial level.[402] Finally, those who support upholding the profession's current name point to the fact that efforts to amend laws, regulations or policies to the contrary could potentially endanger current law or policy because when statutes are "open" for modification, new limiting language can be incorporated within them.[403]

A second issue of wording surrounds the concept of PA "supervision."[404] While the PA profession strongly embraces team practice with physicians, values the depth and breadth of physician knowledge and clinical expertise, and affirms that the team practice model is good for patients, the term "supervision" inadequately describes the method in which doctors and PAs in-

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we have maintained high standards for the profession, we will be certain to have a vital role in the future of health care in this country . . . . What we are called by our patients is not the issue. How we are perceived by them in the care we provide is more important. Our patients expect only the best care they can possibly receive and rightfully so! Their judgment of the quality of care is not always made on the basis of the title of the practitioner who is delivering the service but, more importantly, on the outcome").

400. James F. Cawley, *Get Used To It: Why the Name Change is Impractical*, PA PROF. 27, 27 (June/July 2011) ("Changing the name of the PA profession would be a monumental task where the statutes of virtually all states and legislative jurisdictions, plus all federal and state regulations pertaining to PAs, would need to be amended. This clearly would take decades and millions of dollars.").

401. *AFPPA Membership Supports PA Name Change from "Assistant" to "Associate,"* *supra* note 394.

402. Cawley, *supra* note 400, at 27 ("Changing the name of the PA profession would be a monumental task where the statutes of virtually all states and legislative jurisdictions, plus all federal and state regulations pertaining to PAs, would need to be amended."); *see also* William B. Mosher, *Redefining the Physician Assistant Profession Will Take More Than a Name Change,* THE CLINICAL ADVISOR (Nov. 30, 2011), http://www.clinicaladvisor.com/redefining-the-physician-assistant-profession-will-take-more-than-a-name-change/printarticle/217900/ ("A change to our name will necessitate a great deal of time and expense, ranging from changing federal and state legislation and re-licensing to changing logos and stationery, etc.").

403. *Id.* ("Veterans of state legislative campaigns also know that when a statute comes up for review by the legislature, it presents the opportunity for opposing groups to add unfriendly language/amendments that could unwittingly restrict PA practice or directly undo hard-fought0for prescribing or scope of practice stipulations.").

404. *See* Mosher, *supra* note 402 ("Analogous to a name change is the need to change or clarify the perception of our profession. "Assistant" and "supervision" are two confounding terms that go hand-in-hand to hinder our role in the health-care delivery system. A name change must be accompanied by an accurate redefinition of how a PA is trained, what a PA does and how a PA does it.").

teract.[405] Physicians are not required to be onsite with the PA, to check every aspect of the PA's work, or approve each treatment plan.[406] In nearly all cases, the decision to engage a physician's input rests with the PA.[407] Alt-

405. AM. ACAD. OF PHYSICIAN ASSISTANTS, PROFESSIONAL ISSUES: ISSUE BRIEF: THE PHYSICIAN-PA TEAM (2014), *available at* http://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2497; *See also* The Role and Definition of a Physician Assistant, AAPA HOD Res. 2014-B-02-AFPPA, AAPA 2014 House of Delegates (2014) .(The Association of Family Practice Physician Assistants (AFPPA) put forth a resolution during the AAPA's 2014 House of Delegates to amend the role and definition of the profession, to include the issue of supervision. Their rationale was based in part on the fact that, "On December 24, 2013 the largest employer of PAs in the country, the Veterans Health 30 Administration, enacted a directive updating their policy on utilization of physician assistants including a new definition for PA practice. VHA Directive 1063 established that PAs are professionally responsible for the patient care they provide. . .VHA Directive 1063 defines a Physician Assistant as 'a credentialed health care professional who provides patient centered medical care to assigned patients as a member of a health care team. PA's practice with clinical oversight, consultation, and input by a designated collaborating physician. Although PA's are not Licensed Independent Practitioners, they are authorized to practice with defined levels of autonomy and exercise independent medical decision making within their scope of practice.'" AFPPA went on to assert that, "Many have argued, 'collaborate,' 'collaborating,' 'collaborative' and 'collaboration' are nursing words. The notion that these terms define nursing or represent nurses is false. Merriam-Webster defines supervision as 'a critical watching or directing of activities' whereas collaborating is defined as 'to work jointly with others or together especially in an intellectual endeavor.' The VHA recognized that supervision does not define the role of the PA accurately. The directive established that more experienced PAs should be allowed to work more autonomously than a new graduate. It shows a progression in our abilities as medical providers that is currently missing in our 'supervision' structure. . . The PA profession has a perception problem among legislators, health policymakers, physicians, and patients. The perception is that we need supervision. Although supervision is a regulatory term, stakeholders often mistake supervision to being a global term encompassing our abilities as providers. It propagates the myth that we are "less safe" or provide "inferior care" than our physician counterparts. Study upon study has shown this not to be true, but if we believe that we need to be "supervised" we cannot expect the public think any differently. In contrast to promoting our profession as supervised, collaboration can represent two medical professions working together in a positive relationship. Collaboration is a way of working, organizing, and operating within a practice group or network in a manner that effectively utilizes the provider resources to deliver comprehensive healthcare, in a cost-efficient manner, to best meet the needs of the community."

406. AM. ACAD. OF PHYSICIAN ASSISTANTS, PROFESSIONAL ISSUES: ISSUE BRIEF: SUPERVISION OF PAS: ACCESS AND EXCELLENCE IN PATIENT CARE 2 (2014), *available at* http://www.aapa.org/WorkArea/DownloadAsset.aspx?id=635 ("The concept of supervision does not mean that the supervising physician must always be present with the PA or direct every aspect of PA practice.") *See also* ISSUE BRIEF: THE PHYSICIAN-PA TEAM *supra* note 405 at 2 (2014), *available at* http://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2497 (Within the physician-PA team, as within teams of attending and resident physicians, there is an understanding that the PA is prepared for practice with adequate knowledge and clinical skills. The PA and physician define the PA's role in the practice, the PA consults with and seeks input from the physician whenever necessary for care. As with all practices, duties change over time; PAs assume greater responsibility and autonomy as their experience increases.).

407. RUTH BALLWEG ET AL., *supra* note 101, 744 (5th ed. 2013) ("Although the physician is ultimately responsible for the acts of the PA, the responsibility to ensure that PAs practice in accordance within ethical, legal, and medical standards is shared and reciprocal.

hough there are times when physicians act in a traditional supervisory role with PAs, labeling every physician-PA relationship with "supervision" fails to convey the sophistication of the team and to recognize the vast amount of autonomous decision making involved in PA practice.[408]

According to *Guidelines,* "[t]he guiding principles of supervision must be that it (a) protects the public health and safety, and (b) preserves the physician assistant's access to physician consultation when indicated."[409] While public protection and access to physician consultation are key to safe and effective team practice, it has been suggested that the term "supervision" is no longer appropriate and serves as a barrier to accurate perception of the profession by the public and achievement of legal authority for full scope of practice.[410] The ideal way to address this is to universally refer to physician assistants as "PAs" and to describe the way physicians and PA work together as "collaboration."[411]

VI. THE FUTURE – NEW FOCUS, LESS FIGHTING

On Oct. 1, 2013, the Michigan Senate introduced an omnibus bill (Senate Bill 568), which totaled more than 230 pages, amending several chapters of the Michigan Public Health Code.[412] The intent of the bill is "to reform the current structure of healthcare provider occupational licensing to reflect the changing dynamics of the healthcare marketplace" by addressing scope-of-practice issues for PAs and nurses.[413] The legislation seeks to consolidate the regulations and oversight of allopathic and osteopathic physicians, PAs, and advanced practice registered nurses by repealing parts of the state's public health code to create the Michigan Patient Care Board ("Patient Care

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It is the responsibility of the PA to seek advice and consultation when indicated. PAs are often credited with the strength of "knowing their limits" and understanding when physician input should be solicited.").

408. The Role and Definition of a Physician Assistant, *supra* note 405; *See also* RUTH BALLWEG ET AL., *supra* note, 101 743-4 (5th ed. 2013) ("A central theme of the supervisory relationship between physicians and PAs is the recognition that the physician is the most comprehensively trained member of the team and therefore holds terminal responsibility for ensuring that all members of the team adhere to accepted standards of care. He or she assumes legal liability and professional responsibility for all medical actions of the PA.").

409. AM. ASS'N OF PHYSICIAN ASSISTANTS, GUIDELINES FOR STATE REGULATION OF PHYSICIAN ASSISTANTS 3-4, *available at* https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=795 (last visited Nov. 17, 2014).

410. *Id.* at 4-5.

411. *See* Lawrence Herman, *Tsunami of Change,* PA PROF., May 2014, at 3 ("We have changed how we tell the PA story: specific words have been eliminated from the AAPA vocabulary entirely or diminished to a minimum. We are now simply PAs, just as physicians are MDs [and DOs] and nurses RNs."); *see also* AAPA HOD Res., *supra* note 405.

412. S. 568, 97th Leg., Reg. Sess. (Mich. 2013).

413. Mich. Health and Hosp. Association, Sen. *Jim Marleau Addresses MHA Legislative Policy Panel, Vol.* 44 No. 35 MICH. HEALTH & HOSP. ASS'N, (October 28, 2013), *available at* http://www.mha.org/mha/weeklymailing/2013/102813/monday_report.htm.

Board").[414] The Patient Care Board would reside within the Department of Licensing and Regulatory Affairs and consist of three representatives from each of the aforementioned professions, as well as seven public members, for a total of nineteen voting members.[415]

Reflecting a more modern approach to the way in which medicine is practiced and clinical care is provided, the bill supplants the requirement for supervision with one for collaboration.[416] In order to practice, PAs and nurses would be required to be members of a patient care team with at least one physician. [417] To collaboratively provide patient care, each member of the patient care team must enter into a signed, written practice agreement that would be available to the Board on request.[418] Under the legislation, other facets of PA practice that are embodied within both current Michigan state law and regulation, and the *Model State Legislation,*[419] would remain unchanged.[420] For example, PAs would be licensed health professionals.[421] In addition, the determination of a PA's scope of practice would be based upon an individual's education, training, and experience.[422] Also unchanged is the absence of a mandate for physicians to countersign orders in a patient's clinical record.[423] Lastly, the legislation preserves PA full prescriptive authority and authorizes team interaction using modern methods of communication.[424] In addition, the bill would allow PAs to make calls or go on rounds in collaboration with a physician in all settings, as well as authenticate official forms—even those that list the physician as the required signatory—provided that they have a written practice agreement.[425] Unlike current state law, which limits the number of PAs a physician can simultaneously supervise,[426] the legislation would not impose such restrictions.[427] Although it is unlikely to pass in its current form, Michigan SB 568 represents a breakthrough in innovation and collaboration.[428]

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414. S. 568, *supra* note 412, at 145-46.
415. *Id.* at 60, 145-46.
416. *Id.* at 112-113.
417. *Id.* at 111-13.
418. *Id.* at 158.
419. *See* AM. ACAD. PHYSICIAN ASSISTANTS, MODEL STATE LEGISLATION FOR PHYSICIAN ASSISTANTS, 1-6 (2013), *available at* http://www.aapa.org/WorkArea/DownloadAsset.aspx?id=548 (last visited Nov. 17, 2014).
420. S. 568, *supra* note 412, at 112, 157, 159-160, 165.
421. *Id.* at 112.
422. *Id.* at 159.
423. *Id.* at 160.
424. *Id.* at 157 and 65.
425. S. 568, *supra* note 412, at 160, 68-69.
426. Mich. Comp. Laws Ann. §333.17048 (West 2013).
427. *See* S. 568, *supra* note 412.
428. *Id.*

Over the past five years, organizations of physicians and PAs have also developed a series of joint policy monographs to articulate shared values and key areas of alignment.[429] Included in each joint monograph developed between AAPA and a national physician organization is a statement endorsing the concept that scope of practice is ideally determined by the clinical team. For example, the AAPA and ACP joint monograph encourages "flexibility in federal and state regulation so that each medical practice determines appropriate clinical roles within the medical team, physician-to-PA ratios, and supervision processes, enabling each clinician to work to the fullest extent of his or her license and expertise.[430]

In 2012, the Federation of State Medical Boards, the national organization that represents the nation's seventy medical and osteopathic boards,[431] revised the section on PA regulation in its *Essentials of a Modern Medical and Osteopathic Practice Act* ("*Essentials*").[432] Among other goals, the *Essentials* are developed "to encourage the development and use of consistent standards, language, definitions, and tools by boards responsible for physician and physician assistant regulation."[433] In alignment with AAPA, AAFP, AOA and ACP policies, the *Essentials* call for PA scope of practice to include those medical services that are within the PA's training and expertise, that are delegated by a physician, and form a component of the physician's scope of practice.[434]

Although it may seem counterintuitive, recent action by the Federal Trade Commission ("FTC") has caused states to rethink their approach to scope of practice regulation.[435] In 2013, a North Carolina court ruled that the North Carolina State Board of Dental Examiners ("Dental Board") exceeded its authority when it ordered teeth-whitening kiosks operated by

429. ELLEN RATHFON & GAIL JONES, AM. ACAD. FAM. PHYSICIANS FAMILY PHYSICIANS AND PHYSICIAN ASSISTANTS: TEAM-BASED FAMILY MEDICINE 1-2 (2011) *available at* http://www.aapa.org/WorkArea/DownloadAsset.aspx?id=849.

430. AM. ACAD. OF PHYSICIAN ASSISTANTS & AM. COLL. OF PHYSICIANS, INTERNISTS AND PHYSICIAN ASSISTANTS: TEAM-BASED PRIMARY CARE 2 (2010), *available at* http://www.acponline.org/advocacy/current_policy_papers/assets/internists_asst.pdf; *see also* AM. OSTEOPATHIC ASS'N & AM. ACAD. PHYSICIAN ASSISTANTS, OSTEOPATHIC PHYSICIANS AND PHYSICIAN ASSISTANTS: EXCELLENCE IN TEAM-BASED MEDICINE 5-6, (July 2013), *available at* http://www.aapa.org/workarea/downloadasset.aspx?id=1700 (including similar provisions).

431. *The Federation of State Medical Boards*, FED. STATE MED. BDS., http://www.fsmb.org/ (last visited Nov. 17, 2014).

432. FED'N OF STATE MED. BD., ESSENTIALS OF A MODERN MEDICAL AND OSTEOPATHIC PRACTICE ACT (13th ed. 2012), *available at* http://library.fsmb.org/pdf/GRPOL_essentials.pdf.

433. *Id.* at 1.

434. *Id.* at 30.

435. Thomas W. Elwood, *Patchwork of scope-of-practice regulations prevent allied health professionals from fully participating in patient care*, 32 HEALTH AFF.1985, 1988 (2013).

non-dentists to cease and desist.[436] The U.S. Court of Appeals for the Fourth Circuit sided with the FTC by ruling that the Dental Board was not shielded from anti-trust scrutiny.[437] This, and other recent FTC activity that has held that anti-scope of practice expansion activities are anti-competitive,[438] has caused regulatory agencies to take reexamine their motivation for scope restriction.[439]

Policy alignment, innovative legislators, and the watchful eye of the FTC may bode well for improvements in scope of practice regulation. Diminishing barriers to full practice by PAs can help address state workforce concerns as PAs are more likely to practice in states with fewer scopes of prac-

436. *Id.*

437. *Id.*

438. *Federal Trade Commission Recommendations*, AM. ASS'N COLL. NURSING, http://www.aacn.nche.edu/government-affairs/aprn-advocacy/federal-trade-commission (Last visited Nov. 17, 2014). *See also N.C. State Bd. of Dental Exam'rs v. FTC,* 717 F.3d 359 (4th Cir. 2013). (N.C. GEN. STAT. § 90-22, charges the North Carolina State Board of Dental Examiners (Board), an agency of the state, with governing the practice of dentistry by licensees and applicants. Board members comprise of six dentists that are elected by fellow dentists, a dental hygienist, elected by fellow dental hygienists, and one public member who is appointed by the governor. The Board issued cease and desist letters to non-dentist providers of teeth whitening services upon receiving complaints from fellow dentists about non-dentist provider services being offered at mall kiosks at lower prices and the potential for harm to consumers. The letters caused non-dentist providers to stop providing the service in the state. The FTC issued a complaint in 2010 charging the Board with engaging in anti-competitive activity. *See specifically N.C. State Bd. of Dental Exam'rs v. FTC,* 717 F.3d 359, 365 (4th Cir. 2013). The Board moved to dismiss the complaint stating that it was exempt from federal antitrust laws under the state action doctrine. The state-action doctrine provides immunity from federal antitrust liability for certain state-mandated activities. If the state acts under its legislative authority or if a private actor acts under the authority and oversight of the state, the action is exempt from antitrust liability. Based upon a determination on by an administrative law judge that the Board's actions were a violation of the FTC Act, 15 U.S.C. § 45, by engaging in unfair competition in the market for teeth whitening services, the motion was denied. The Board appealed the administrative law judge's holding, which was affirmed on appeal. The Board then petitioned the United States Court of Appeals for the Fourth Circuit for review of the FTC's final order, which was denied. The Board then petitioned the United States Supreme Court for review, which was granted. On October 14, 2014, the Supreme Court heard oral arguments in Case 13-534 North Carolina State Board of Dental Examiners v. the Federal Trade Commission). *See also* FTC Staff Comment Before the Alabama State Board of Medical Examiners Concerning the Proposed Regulation of Interventional Pain (November 3, 2010) Management Services *available at* http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-alabama-state-board-medical-examiners-concerning-proposed-regulation/101109alabamabrdme.pdf. The FTC asserted that the Board's proposed rule which sought to provide that interventional pain management services be performed exclusively by physicians appeared overly restrictive and likely detrimental to Alabama patients. The comment also explained that the proposed rule would reduce the availability and raise the prices of chronic pain management services.

439. JACK R. BIERIG, ANTITRUST IMPLICATIONS OF SCOPE OF PRACTICE AND OTHER REGULATORY ACTIONS OF STATE BOARDS OF MEDICINE, 1-3 (2011), *available at* http://www.fsmb.org/pdf/2011_grpol_Antitrust_Implications_of_Scope.pdf.

tice barriers.[440]

VII. CONCLUSION

After nearly a half century of state regulation of the PA profession, it is evident that PAs can enter the healthcare workforce much more quickly than physicians and can adapt to meet workforce needs across specialties and settings.[441] Further, care provided by PAs is indistinguishable in quality from care provided by physicians, and PAs are well accepted by patients.[442]

The ACA incentivizes new models of care and requires more people to obtain health insurance.[443] This should serve as an accelerant to changes already underway in US healthcare, specifically the move toward a focus on population heath and the shift toward fee-for-value systems.[444] The success, acceptance, and utility of the profession are due in large part to PAs' sustained partnership with physicians.[445] The model of clinical autonomy within a team harnesses the clinical efficiencies of each member of the team.[446]

Determining scope of practice based on competency allows for rapid re-

440. Janet P. Sutton et al., *US Physician Assistant (PA) Supply by State and County 2009*, 23 J AM. ACAD. PHYSICIAN ASSISTANTS E6-E7(2009) *available at* https://www.academia.edu/392405/US_Physician_Assistant_PA_Supply_by_State_and_County_in_2009.

441. Anita D. Glicken & Anthony A. Miller, *Physician Assistants: From Pipeline to Practice*, 88 ACAD. MED. 1883, 1883 (2013), *available at* http://www.ncbi.nlm.nih.gov/pubmed/24128623.

442. Harold C. Sox, Jr., *Quality of Patient Care by Nurse Practitioners and Physician's Assistants: A Ten Year Perspective*, 91 ANNALS INTERNAL MED. 459, 459 (1979) (discussing the high level of PA care); *see also generally* OFFICE OF TECH. ASSESSMENT, CONG. U.S., HEALTH CARE IN RURAL AMERICA (1990), *available at* http://babel.hathitrust.org/cgi/pt?id=umn.31951p00265485q;view=1up;seq=8 (citing various examples of PA utilization in delivery of rural healthcare).

443. *See* Dower et al., *supra* note 98, at 1972.

444. Kole, *supra* note 315, at 21; NAT'L COMM'N ON PHYSICIAN PAYMENT REFORM, REPORT OF THE NATIONAL COMMISSION ON PHYSICIAN PAYMENT REFORM 14 (2013) (The long-range solution is a system that provides appropriate, high-quality care that emphasizes disease prevention rather than treatment of illness and that values examination and diagnosis as much as medical procedures. This implies a shift from a payment system based on fee-for-service to one based on value through mechanisms such as bundled payment, capitation, and increased financial risk sharing.).

445. PEW HEALTH PROFESSIONS COMM'N, UNIV. OF CALIFORNIA, SAN FRANCISCO, CENTER FOR THE HEALTH PROFESSIONS, CHARTING A COURSE FOR THE 21ST CENTURY: PHYSICIAN ASSISTANTS AND MANAGED CARE 27 (1998) (describing the traditional working relationship between PAs and physicians, and how the elements of this relationship [consultation, referral, review] form the basis of successful professional healthcare relationships in general).

446. RATHFON & JONES, *supra* note 429, at 5 ("The PA autonomously performs appropriately delegated medical care. Thus, the care provided by the PA is directed and its quality is assured by the physician. The most effective physician-PA team practices provide optimal patient care by designing practice models where the skills and abilities of each team member are used most efficiently.").

sponse to patient needs and incorporation of technological advances, while the modernization of language used in regulating the profession may promote more effective utilization of PAs.[447]

Moving forward, increased information and metrics, as well as patient expectations and preferences, will play a heightened role in healthcare. [448] If laws and systems can adapt to incorporate new information and address patient expectations, then cost, quality, and access goals can be met.[449]

Mandating that states protect those within their borders by licensing health professionals allows patients to contact local agencies to verify credentials or file a complaint.[450] However, using the slow, expensive, and highly-politicized state legislative process to determine scope of practice yields unscientific and idiosyncratic results.[451] This can be mitigated by adopting systems that require states to license PAs and physicians, allowing them to work together in teams that expand access to care and attend closely to the clinical tasks at hand. Empowering clinicians to determine scope of practice allows quality, cost, access, and patient care goals to be met.[452]

447. *See* Dower et al, *supra* note 98, at 1974.

448. Jonathan P. Weiner et al, *The Impact of Health Information Technology and E-Health on the Future Demand for Physician Services*, 32 HEALTH. AFF. 1998, 1999-2001 (2013).

449. *See* Dower et al., *supra* note 98, at 1975-76.

450. THE SPECIAL COMM. ON UNIF. STANDARDS AND PROCEDURES, FED'N OF STATE MED. BD., MAINTAINING STATE-BASED MEDICAL LICENSURE AND DISCIPLINE: A BLUEPRINT FOR UNIFORM EFFECTIVE REGULATION OF THE MEDICAL PROFESSION 2 (1998), *available at* https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/1998_grpol_Uniform_Standards_and_Procedures.pdf ("The Federation strongly believes that the state-based system retains a flexibility and sensitivity to local concerns that would inevitably be lost in a national system, and allows for the evolution and testing of a range of new approaches to improve the regulation of the medical profession in a number of jurisdictions at once.").

451. *See* Dower et al., *supra* note 98, at 1972-73.

452. *Id.* at 1974.