

Is physician assistant autonomy inevitable?

Roderick S. Hooker, PhD, MBA, PA

After a half-century of development, the physician assistant (PA) movement is robust, dynamic, and has moved onto the world stage in ways its creators never imagined.¹ One of the recurring topics discussed by PAs, nurse practitioners (NPs), and physicians is the autonomy of PAs and advanced practice registered nurses. A historical connection with organized medicine endeared the PA to physicians as befitting a dependent relationship. Such professional groups as the American Medical Association, American Osteopathic Association, Association of American Medical Colleges, and American Academy of Family Physicians greeted PAs warmly because of a mutual interest—keeping physicians in the leadership role of medicine. On the other hand, the coolness of physician associations to the independence of NPs has been palpable.² This causes some tension between the three health professions. NP animosity sometimes spills over to PA rhetoric on the subject and vice versa. However, as of 2015, NPs are independently licensed in 19 jurisdictions and such licensure in all states seems inevitable.

At the same time, there is little uncertainty for PAs that change is coming in many ways and many forms. One of the ways is the trend toward autonomy. This self-sufficiency is not so much a push as a pull. The AAPA is not pushing nor is there a concerted effort to do so on any other front. What is pulling is history—the inevitable evolution of a profession: the tendency to be self-sufficient and self-governing. A cavalcade of observers has noted the trend of dependent occupations to eventually succeed to positions of independent licensure. These begin with psychology, optometry, and podiatry, then include physical therapy, audiology, occupational therapy, and nurse anesthetists, to name a few.

The evolution of legislation and regulation over the past 4 decades has been remarkable. In this short span, all states and most territories now enable PAs to practice, prescribe treatments and devices, and be reimbursed for their services. Many states permit PAs to be semi-autonomous and function in remote locations. In Alaska, physician supervision has been changed to collaboration to be consistent with

NPs. The federal government, the largest single employer of PAs, has decided that autonomy is appropriate.^{3,4} The outcome of care guides this policy—if PAs were not safe they would not be employed. In the Netherlands, PA-independent licensure has emerged as well. This stems from a strongly held belief about the nature of professional independence. Such autonomy seems an inevitable change if history is to repeat itself and patient safety is not compromised.

Schneller argues that occupations that are designed as subordinate to the more powerful and prestigious professions have built-in limits to the degree to which they can acquire valued professional attributes. Using the PA occupation as an example, he believes the general model of professional development cannot adequately deal with the evolutionary process of the PA because the PA entered into a “negotiated, semi-autonomous dependent relationship with the supervising doctor.”⁵ Serve the physician or become independent.

A cavalcade of observers has noted the trend of dependent occupations to eventually succeed to positions of independent licensure.

The way may be paved for PAs in the second half-century of development. The NP movement has both success and momentum, and is clearing the legislative ground that the PA profession also treads. The efforts to stem this advance seem more self-serving than society-serving...and also fruitless because enabling legislation rarely backslides when it involves the expanded role of health professionals. If PAs and NPs are viewed as fungible, then why grant independent license to one and not the other? Some states have passed elements of model legislation permitting PAs to obtain a license independent of a physician (although they are not permitted to work until they have a supervising physician).

The physician's perspective should be viewed through an economic lens as well. Why would physicians want the

Roderick S. Hooker is a retired PA and health policy analyst. The author has disclosed no potential conflicts of interest, financial or otherwise.

DOI: 10.1097/01.JAA.0000458863.55688.a0

Copyright © 2015 American Academy of Physician Assistants

liability of PAs when they can employ NPs who are independently licensed and answer for themselves? What corporation would not find NPs easier to employ if they hold independent licenses rather than needing a supervising physician? If both have similar liability profiles, then the line of least resistance is to choose the independent NP over the dependent PA.⁶ The ability to employ independent licensed NPs in retail clinics, urgent care centers, veterans health administration treatment facilities, and community health centers is a contemporary business model that works well with limited or no supervisory partnerships.

The fading image of organized medicine needs to be considered as well. One view is that professional relationships between the AAPA and medical associations appear more perfunctory than strategic. PA leaders may espouse close relationships with physicians, but any reciprocal feelings may not be returned as younger physicians take over the leadership of their organizations and are indifferent to old covenants. In the end, the measure of PAs is what they produce in a clinic or at the bedside, not how good of a handmaiden they are to the physician. Outcomes of care delivered by PAs are documented more and more—only sometimes is the outcome the result of team-based strategy in primary care led by a physician. Unless proven otherwise, in most ambulatory care settings where first contact with

a PA or NP is the norm, the PA and NP are viewed in much the same way as the physician.^{7,8} The notion of the PA and physician joined side-by-side is fading as a more mature and autonomous PA emerges. **JAAPA**

REFERENCES

1. Hooker RS, Robie SP, Coombs JM, Cawley JF. The changing physician assistant profession: a gender shift. *JAAPA*. 2013;26(9):36-44.
2. Chen P. The gulf between doctors and nurse practitioners [blog]. *New York Times*. June 27, 2013. http://well.blogs.nytimes.com/2013/06/27/the-gulf-between-doctors-and-nurse-practitioners/?_php=true&c_type=blogs&r=0. Accessed October 8, 2014.
3. Mundell BF, Friedberg MW, Eibner C, Mundell WC. US military primary care: problems, solutions, and implications for civilian medicine. *Health Aff*. 2013;32(11):1949-1955.
4. Petzel RA. Veterans Health Administration directive 1063. Utilization of physician assistants. December 24, 2013. <http://www.va.gov/oa/directives.asp>. Accessed October 8, 2014.
5. Schneller ES. *The Physician's Assistant: Innovation in the Medical Division of Labor*. Lexington, MA: Lexington Books; 1978.
6. Hooker RS, Nicholson J, Le T. Does the employment of physician assistants and nurse practitioners increase liability? *J Med Licensure Discipline*. 2009;95:6-16.
7. Hooker RS, Everett CM. The contributions of physician assistants in primary care systems. *Health Soc Care Community*. 2012;20(1):20-31.
8. Hooker RS, Benitez JA, Coplan BH, Dehn RW. Ambulatory and chronic disease care by physician assistants and nurse practitioners. *J Ambul Care Manage*. 2013;36(4):293-301.