The Power of Two: Revisiting PA Autonomy

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PA autonomy is a hot topic lately—not just within the profession but also in the public press. Earlier this year, *Forbes* touted efforts to loosen "barriers" to PA practice.[1] The American Academy of Physician Assistants has identified 10 federal regulations that impose "unnecessary barriers" to medical care provided by PAs; these include cumbersome countersignatures, unnecessary supervision, and ordering restrictions on everything from home care to diabetic shoes.[2] Lifting these barriers makes sense amid a shortage of physicians and an influx of newly insured patients (for more on this topic, see page 9). But as we acquire greater autonomy, we must not lose sight of the relationship that our profession was founded on—and that makes it unique.

Many PAs aspire to be truly independent practitioners, and some already are (eg, in remote and rural areas). Those of us who practice more closely with physicians may be more apt to appreciate the PA-physician partnership. In my 12 years as a PA, I have partnered with more than 50 physicians in cardiology, internal medicine, gastroenterology, and surgical oncology. I have also had the opportunity to witness the dynamic of other PA-physician relationships. As with all relationships, there is a wide range in synergy, productivity, and trust. Some ill-fated relationships are toxic and nonproductive; those merit a swift exit. At the other end of the spectrum are star-crossed partnerships that radiate competence, creativity, and confidence. In between these two extremes are the majority of PA-physician duos, working it out day to day in a kaleidoscopic health care world. It is clear that the physicians and PAs who not only work hard individually, but also work well within their relationship, benefit the most—and so do their patients.

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We surgical PAs have a privileged bond that forms at the operating table. It is not only essential, but empowering, to know what each surgeon is thinking about his or her patient as the case unfolds. In medicine, collaboration may not be as intimate as it is in surgery. Still, there is no substitute for knowing our physicians well. Are our treatment goals in sync with theirs? Are we saying the same things to our patients? When we differ (as we often do), how do we achieve respectful and creative dissention? Can we each do our own thing and still be a credible and productive team?

What exactly *is* PA autonomy? Our scope of practice is delegated by a supervising physician and is limited to the services for which the physician can provide adequate supervision. The terms of supervision vary by state and by practice. In some states, a PA can have multiple "substitute" supervisors, as long as someone keeps a current list. The primary physician supervisor may or may not be the one the PA works with most closely. Some supervisory relationships are merely paper ones, a *de rigueur* document for the licensing file. Whatever form it takes, supervision has legal and clinical implications that should be implicit to both parties.

If supervision changes drastically, and PA autonomy becomes a reality, the name of our profession would have to change. *Physician associate* has been proposed. But until we eliminate the word *physician*, we are still partners with the very profession from which we intend to secede. Certainly, we need to abolish the possessive *physician's* (a semantic that rankles universally). Let us get rid of that annoying (and misleading) apostrophe once and for all.

Many of us chose to become PAs to be extenders, rather than bearing ultimate responsibility. That is not to say that we are not willing to make decisions, take risks, or accept liability—that comes with the license and the territory. But in choosing to assist, we have deliberately chosen a dependent role. While physician *assistant* indeed implies a subordinate relationship, it is not necessarily a subservient one. There is plenty of room for both shared and separate decision-making, for specifically delegated or situational authority. The PA-physician relationship is built on mutual trust that is earned and reinforced on a daily basis. Decisional confidence and technical competence—not wimpy dependence—is the product of a dynamic PA-physician relationship.

As the health care market changes, we can and should afford ourselves every professional opportunity to work as salaried providers or to sign on as single contractors. There are many alternative PA-physician relationships, both legally and financially. If we so desire, we should pursue advanced degrees and specialty certifications and be compensated accordingly. However, multi-tasseled resumes should remain optional. They are costly and not within the reach of everyone, nor do they necessarily make a better PA.

In this new age of autonomy for advanced practice providers, some will say that only a dinosaur could have made these comments. If that is true, thank you for allowing me to wag my tail. The fact remains that PAs offer something unique. In an era of serious physician shortages, we offer patients the opportunity to have both a relationship with their internist, surgeon, or specialist *and* access to our own capable care and treatment. This is the "package deal" that, sadly, is in danger of becoming overlooked—if not extinct. **CR**

REFERENCES

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