A Case for Supporting the Full Autonomy of Nurse Practitioners and Physician Assistants

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Outline

1. Introduction

    a. Topical situation of 2020 viral outbreak and the utilization of all healthcare workers

    b. Current healthcare delivery system has well defined chain of command

    c. Vague outline of healthcare delivery system

    d. Physician's responsibility and patient input

    e. Patient-doctor one on one is rapidly fading amidst this current delivery system; physician shortage

    f. Rise in affordable health insurance with more enrollees than ever before

    g. The elimination of physician supervision of NPs and PAs is worthwhile when considering their role in aiding underserved areas, easing the impact of an expanding healthcare marketplace, and when examining their presently expanding levels of autonomy

2. Current NP and PA scope of practice laws and regulations

    a. Up to date NP laws, citing twenty-five "full practice states", and another nineteen comparable state laws

    b. Up to date PA laws; PAs work within healthcare teams among other providers and via collaborative relationship with a supervising physician

    c. However, PAs do not require physical presence of the supervising physician, and work within rural clinics and off-site facilities

    d. Lack of cohesion from state to state and from provider to provider

e. “Should nurse practitioners treat patients without physician supervision?” (Cooke, 2015, p.713)

3. Rapidly evolving roles

a. Current implications of the national public health crisis; an “all-hands-on-deck” perspective better suited in times of hardship and larger magnitude

b. This new normal may lead to a sweeping overhaul, appreciation, and importance of non-physician providers

c. Natural progression and evolution of other healthcare providers throughout history

d. “Is Physician Assistant Autonomy Inevitable?” (Hooker, 2015, p. 18)

e. Remarkable hurdles achieved in the laws and regulations of NP and PA scope of practice over the past few decades

f. “Is Physician Assistant Autonomy Inevitable?” (Hooker, 2015, p. 18)

g. The simplicity that comes with PA autonomy and independent licensure for the workplace employing them

4. US Department of Health and Human Services projection on primary care

a. Cited projections by 2025 on supply and demands of primary care physicians
b. National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025 (p. 8)
c. Alongside this deficit, NP and PA enrollment and graduation rise
d. National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025 (p. 14-15)
e. New student doctors choosing other fields

f. “Using Advance Practice Registered Nurses and Physician Assistants to Ease Physician Shortage” (Selena Hariharan, 2015, p. 46)

5. Affordable Health Care Act

a. The passing of the Affordable Health Care Act has opened the option for millions of more Americans to hold affordable health insurance coverage
b. Laws need to be enacted to meet this growing demand for services
c. President Trump’s Executive Order on Protecting and Improving Medicare for Our Nation’s Seniors and its implications for the NP and PA community
d. The effort is to streamline an already overburdened system, and create cohesion from state to state

6. Aiding rural, poor, and underserved areas of the country

a. Many times, PAs and NPs are already viewed as “doctor”
b. “Is Physician Assistant Autonomy Inevitable?” (Hooker, 2015, p. 20)
c. “The effects of expanded nurse practitioner and physician assistant scope of practice on the cost of Medicaid patient care” (Edward Timmons, 2015, p. 195)
d. Research supports that NPs and PAs provide lower costs on healthcare to low-income Americans
e. “The Non-Physician Remedy to the Physician Shortage” (Thomas Hemphill & Gerald Knesek, 2015, p. 3)
f. Possibly NP and PA implications for the shortages noted in the specialty field of Psychiatry

7. US Department of Veteran’s Affairs (VA)

a. Remains at the forefront of how to implement and integrate these non-physician providers into a healthcare delivery model
b. The very concept of PAs began in the US military
c. “VA Modernizes the Way Physician Assistants Practice in Four Ways” (Hanson, 2014, para. 8)
d. December 2013 VA Directive 1063 (A4-5)
e. How PAs are utilized within the VA Healthcare system, relative to their experience
f. “VA Modernizes the Way Physician Assistants Practice in Four Ways” (Hanson, 2014, para. 6)
g. Why PAs are equipped for treating patients in primary care and the forward thinking of the VA to alleviate doctor shortage impacts

8. Refutations

a. Opposing sides views on educational gaps of NPs and PAs
b. (Practicing Physicians of America, 2020, para. 20-22)
c. Medical Economics cites the opposing sides claims within survey results of their physician reader base
d. (Bernard, 2018, p. 56)
e. Graduate Physician Act; its proposals and implications if passed
f. (Pereira, 2020, para. 1-5).
g. A large roadblock in the way to a more streamlined delivery care system and the battle for recognition

9. Conclusion

a. NPs and PAs would not uproot physicians, but help to bolster the healthcare system

b. NP/PA education lies in hands-on learning and experience with patients

c. New opportunities can arise for both sides (NPs/PAs and physicians)

d. Physicians can stray away from mundane tasks and begin to focus on specialties

e. Physician's necessary footing in carrying out research and investigation into illness

f. NPs/PAs have operated as "doctor in charge" for years, working in all essential areas

A Case for Supporting the Full Autonomy of Nurse Practitioners and Physician Assistants

Of the many lessons to be learned, and insights gleaned from our current battle against the viral contagion of 2020, we see it evident that the medical profession is extremely adept at marshalling both resources and manpower to combat any threat to public health. On lesser display is the continued nationwide shortage of qualified physicians across the board from specialists to primary care providers. This is an ongoing concern. Regardless of why, a physician-led team approach is the modality of the moment. Pandemic or not, the accepted norm of our current health care distribution network works best when there are clearly defined chains of command and descending hierarchy. The natural progression model indicates a licensed, professional physician at the forefront of the team, with a cadre of nurse practitioners, physician assistants, nurses, and various technicians, as laboratory and diagnostics would dictate. All of these healthcare providers are initially trained in their specific areas of expertise, and licensed and registered on both state and national levels, to practice medicine. Continuing education is another on-going concern. Every strata of this healthcare model is responsible for reporting to the physician in charge. It is the physician's responsibility to coordinate and manage the patient care with input from all of the team members ensuring a consensus and an agreed upon outcome. It is also essential that along this discussion route, the input from the patient and/or family members is also considered.

The physician-led approach to medical care is not a new or radical concept just now finding fashion. However, the days of patient-doctor one on one is rapidly fading as the method of choice. Statistics will bear out that the physician shortage is a true phenomenon. In fact, research into the future of doctor centered health care delivery all indicate the same trend of less qualified doctors and providers to fill the needs of an expanding population as well as other

opportunities now available to graduate student-physicians. Additionally, the rise in affordable health insurance has opened the door for more people to enter the healthcare marketplace, increasing additional existing caseloads of physicians as much as opening up areas of the country heretofore untapped as potential patient customer. In the wake of such discernable odds, there is value in considering restructuring nurse practitioner and physician assistant autonomy and removing physician supervision laws when weighed alongside the known realities of easing healthcare shortages in underserved areas, understanding the impact of an ever-expanding healthcare marketplace, and upon examination of the inevitable evolving roles of nurse practitioner and physician assistant.

Enter the importance and influence of nurse practitioners (NPs) and physician assistants (PAs). These two types of providers have always maintained a vital role in the delivery of modern medical care. Detailed within the American Association of Nurse Practitioners "State Practice Environment" guidelines of December 20, 2019, are the many contrasting "scope of practice laws" and regulations in the United States. Across twenty-five different states, NPs and PAs conduct a wide array of medical services to include diagnostics and treatment plans, as well as prescribing controlled substances and other pharmacological needs. According to the "State Practice Environment" guidelines, these providers practice "…under the exclusive licensure authority of the state board of nursing" and are referred to as "full practice states" (para. 1). Another nineteen states operate on a comparable scale, reducing their scope by at least one fundamental service area (para. 1-2).

Similarly, the supervision requirements, prescriptive authority, and scope of practice decisions of physician assistants are determined by state medical boards or set up at the practice level; between the PA and the supervising physician, as identified in the Scope of Practice Policy

Guidelines of 2020. These guidelines are made available by the National Conference of State Legislators and serve as a publicly utilized source for up to date clarification on state laws and regulations. While there are twenty-five states identified above as NP "full practice states," PAs work via collaborative relationship with a supervising physician. These medical professionals practice alongside other providers and physicians within a team healthcare delivery system. PA occupational licensing laws do not require that the supervising physician be in physical presence of the PA when services are performed, but available for consultation (para. 1-3). This also means that PAs staff offsite clinics and other rural walk-in facilities. These current limits and restrictions imported on NPs and PAs which vary from state to state hinder the cohesiveness from both a patient and provider perspective. Cindy Cooke (2015) DNP, FNP-C, FAANP, the former president of the American Association of Nurse Practitioners, composed a pro-stance review for the *CQ Researcher* debate column titled "Should nurse practitioners treat patients without physician supervision?" In this article, she expresses her position by stating that "nurse practitioners should be authorized to treat patients… and they should be recognized as expert clinicians. States have long allowed nurse practitioners to practice without supervision, some for decades. This has produced extensive data that overwhelmingly show nurse practitioners with such authority have patient outcomes equivalent to those of physicians- not a surprise considering that their highly focused education is specifically designed to provide this very expertise" (p. 713).

As mentioned previously, these current roles for NPs and PAs are rapidly evolving, nonetheless. Specifically, during these times of a national public health crisis where the all-hands-on-deck availability to the problem far outweighs a review of one's specific set of credentials and/or educational pedigree. When confronted with the magnitude of the situation,

the doctor's creed of "first do no harm" never seemed so prophetic. Among all aftermath, the new normal might result in a sweeping overhaul of how we view and consider the contributions of non-physician practitioners. Providentially, there is a natural evolution that can be noted amidst the backdrop of other medical professions throughout history. This progression is emphasized in the article "Is Physician Assistant Autonomy Inevitable?" written by Roderick S. Hooker (2015) PhD, MBA, PA, a retired PA and health policy analyst, and published in the *Journal of the American Academy of Physician Assistants*. Hooker (2015) outlines the trends of "…dependent occupations [that] 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" (p. 18). He also complements Cooke's (2015) viewpoints on NPs by adding the following comments on PAs; "the evolution of legislation and regulation over the past 4 decades has been remarkable… Many states permit PAs to be semi-autonomous and function in remote locations… If PAs and NPs are viewed as fungible, then why grant independent license to one and not the other?" (p. 18). These remarks suggest why physician employers and corporations would believe it to be simpler when hiring PAs; as they would now hold their own independent licensure, be able to answer for themselves, and no longer require a supervising physician along the course of the patient relationship (p. 18).

In considering further support for the autonomy of NPs and PAs, we can point to several areas as being deciding factors in not just accepting the status quo. In the US Department of Health and Human Services projection on primary care practitioners, supply and demand calculations for 2025 continue to cite the decline in trained primary care physicians across the country. The National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025 states that given the current structure of healthcare delivery and staffing

patterns, "…the greater increase in demand compared with the increase in supply will result in a projected deficit of 23,640 FTE [full time employee] primary care physicians by 2025" (p. 8). In contrast, the enrollment, graduation, and placement of NPs and PAs has grown exponentially alongside this decline (pp. 12-15). As more physicians graduate from medical schools with specialized degrees, the resulting supply gap of primary care doctor to patient becomes evident. In the article "Using Advance Practice Registered Nurses and Physician Assistants to Ease Physician Shortage," written by Selena Hariharan (2015), MD, MHSA, and published in *Health Care Professionals*, she highlights this distinct change in new student doctors. "Not only is the American population changing, the demographics of physicians are changing, too. Current medical school graduates report feeling that general medicine is neither financially nor personally satisfying as a career choice" (p. 46). These gaps in delivery of service are often filled by qualified NPs and PAs operating in a front-line capacity. As doctors in every sense of the word.

An additional variable to consider in the cause of physician shortages is the present state of the affordable health care system. With the passage of the Affordable Health Care Act in 2010, increases in the numbers of new enrollees in state Medicaid and Medicare programs, et al, healthcare coverage is now available to more people than ever before, adding to existing and projected patient-customer caseloads. Laws and regulations need to be enacted and implemented to meet this growing demand for services. Affordable healthcare should also mean quality health care. In an effort to meet these shortages head on, the federal government has proposed additional restructuring of existing laws as they pertain to the Medicare program for seniors and the medical providers. In an October 2019 proposed executive order, President Donald Trump and government officials present their opinions on loosening and outright eliminating certain

regulations as they regard Medicare reimbursements, insurance disparities, as well as offering support that allows non-physician practitioners more freedom and autonomy in their roles in health care delivery. The Executive Order on Protecting and Improving Medicare for Our Nation's Seniors states "proposing a regulation that would eliminate burdensome regulatory billing requirements, conditions of participation, supervision requirements, benefit definitions, and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their profession" (section 5, subsection a). The effort is to streamline an already overburdened system, and as outlined previously, many states have already permitted NPs and PAs certain levels of autonomy in a variety of situations.

In many instances, especially in the rural, poor, and underserved areas of the country, an NP or PA may be the individual patient's first ever contact with a health care professional, and as such they are considered to be, and often times addressed as "doctor." Hooker (2015) exemplifies this common misconception saying "…in most ambulatory care settings when first contact with a PA or NP is the norm, the PA and NP are viewed in much the same way as the physician" (p. 20). In addition to this discovery, a research study targeting the proposed expanded practice on the cost of Medicaid recipient care and drug costs found further support for the positive impacts NPs and PAs have on the underserved communities of the US. In the 2017 research article "The Effects of Expanded Nurse Practitioner and Physician Assistant Scope of Practice on the Cost of Medicaid Patient Care" written by Edward Timmons who works for the Department of Business at Saint Francis University, and published in *Healthy Policy,* disseminates the findings of his regression analysis on providing healthcare to low-income Americans. "…results suggest that broader scope of practice for PAs is correlated with cheaper

outpatient care (an 11.8-16% reduction, depending on specification) without negatively affecting intensity of health care" (p. 195). It is evident the differing provider will deviate the price which is set by Medicaid reimbursement rates within each state (p. 194). Another significant provider shortage can be seen in the field of psychiatry. Thomas Hemphill and Gerald Knesek, professors at the University of Michigan, instruct how PAs and NPs could also help to mitigate psychiatric mental health needs in their article "The Non-Physician Remedy to the Physician Shortage", published in the 2015 *Regulation* periodical. They advise "the use of non-physician clinicians is one way to help meet the psychiatric mental health needs of patients now facing long waits for appointments with psychiatrists" (p. 3). However, according to the Association of Nurse Practitioners, Hemphill and Knesek convey that only 3.2 percent of NPs are certified in Psychiatry, and that growth in either M.S. in Nursing or Doctor of Nursing Practice degree programs would create curiosity and concentration in this specialty (p. 3). This concern for public health requires harmonious intervention of both state regulations and improved educational standards to better meet the needs of confronting medical shortages. Just as we should not limit the future interests of future NPs and PAs.

As the country's largest employer of nurse practitioners and physician assistants, the US Department of Veteran's Affairs (VA) remains at the forefront of how to implement and integrate these non-physician providers into a healthcare delivery model. It should be noted that the very concept of PAs began in the US military services and continues to thrive in the VA's creation and management of hundreds of VA hospitals and out-patient clinics. Christopher Hanson, a PA employed in the VA with over 30 years of experience describes within a personal editorial on February 1, 2014 titled "VA Modernizes the Way Physician Assistants Practice in Four Ways" made available on the *Physicians Practice* website, that when you "work with PAs,

you can likely attest to the value of having another provider around who shares diagnostic and therapeutic reasoning. That's because PAs are educated like physicians via an intense graduate-level medical program, and that education occurs often side-by-side with physicians in medical schools and residency programs. We think alike because we both practice medicine" (para. 8).

The VA is successful in recognizing the realities of modern team creation and collaboration instead of the top-down supervision and directives. In the December 2013 VA Directive 1063 the following changes were employed, and descriptions summarized for clarity of provider and consumer. "PAs function as health care providers with varying levels of autonomy and exercise independent decision making within their Scopes of Practice. The level of autonomy and degree of involvement of the collaborating physician in the PA's clinical activities varies depending on the PA's practice setting, clinical competence, complexity of the patients treated, and the nature of the assigned duties. Changes in the level of autonomy in the PA's Scope of Practice will be upon recommendation from the collaborating physician or the Chief of Service. Such recommendations should be based on the PA's level of competency and clinical proficiency" (A-4, A-5). This amendment fully corroborates both the practicality levels and rationale in utilizing PAs based on their differing knowledge and experience as it also lessens administrative workload on leaders. "Full" practice autonomy is suitable for PAs that are qualified and where "clinical competence has been demonstrated in carrying out assigned patient care responsibilities. This level may also be used when the PA performs lower risk outpatient therapeutic and diagnostic procedures common to the area of the PA's practice" (A-5). This level of autonomy is appropriate for inpatient and outpatient settings such as Community Based Outpatient Clinics, Long Term Care, Home Based Primary Care, and Telemedicine (A-5). Newly appointed PAs completing training as well as higher risk procedures and patient care

operate under stricter degrees of collaboration (A-5). Hanson (2014) commends this composition by stating, “medicine relies not only on strong training in pathophysiology, but also on experience and pattern recognition, which only comes from time, and direct contact with thousands of patients” (para. 6). Hanson (2014) also adds that “these new guidelines demonstrate not only how versatile and dynamic PAs can be when it comes to practicing medicine, but the VA's confidence in the quality of care PAs can render autonomously to the millions of veterans and others who rely on the federal healthcare system” (para. 13). These successful examples of problem solving, and forward thinking bodes well for the future of NP and PA autonomy.

In response to President Trump’s Executive Order of Protecting and Improving Medicare for Our Nation’s released on October 3, 2019, The Practicing Physicians of America, advises the public in an open-forum post published on January 10, 2020 which examines the distinct differences in the 1,000 hours of clinical education an NP receives versus the 20,000 hours for that of a Physician. The group also adds that many newer graduates originate from online led programs as opposed to attending medical based schools, both lowering the standard of training that was received and further fostering a less competent workforce of our future (para. 20-22). Similarly, Rebekah Bernard MD, is a board member of the Physicians for Patient Protection grass-roots organization, an advocacy group for physician-led healthcare. She shares with the *Medical Economics* 2018 magazine in the article “What’s Ruining Medicine”, an exposition written in response to their physician readers’ annual survey. Bernard (2018) voices that “physicians should be extremely aggressive if doing true supervision and not just sign off on charts. Understand their knowledge base and there should be true collaboration,” which provides rationale behind the survey’s results, classifying “replacing primary care physicians with

NPs/PAs" as the fifth most identified reason for what is ruining medicine for physicians amongst their physician reader base (p. 56).

To further support and strengthen their arguments for continued close monitoring of NPs and PAs, the opposition cites another piece of pending legislation known as the Graduate Physician Act. In a January 17th, 2020 editorial titled "A New Type of Physician: The Graduate Physician" posted on the Practicing Physicians of America's open forum, Megan Pereira, a student doctor, explains the proposed legislation that would allow for the creation of "graduate doctors (GPs);" graduate level medicals students who have completed their standard med school programs as well as completing their first two medical license exams. GPs would provide a higher level of primary care services than currently offered from the normal physician to NP/PA model. There would be no provision in this proposal for a GP to be supervised by the consulting physician (para. 1-4). This creation of yet another roadblock on the way to complete autonomy for NPs and PAs illustrates the ongoing battle for professional recognition and respect that is already evident in the politically charged and competitive landscape of medical care delivery.

In conclusion, NPs and PAs are not seeking to uproot or diminish the qualified physician as primary healthcare provider, but rather bolster and augment the system by their presence in the hospital, clinic or other medical setting. Where one can point out the educational discrepancies between doctors and NPs/PAs as the sticking point in the autonomy argument, the counterargument might address the fact that there are many, varied ways of learning and achieving educational balance. NPs and PAs often make up for the lack of academic learning with a more hands-on, on-the-job training resume. Through repetition many have attained numerous hours of real-life experience in dealing with various patient caseloads. Similarly, by allowing NPs and PAs to perform at the highest level of their competencies, opportunities for

professional and personal fulfillment can open up for both physician and non-physician providers. NPS and PAs for example can pursue educational advancements by entering specialized, understaffed areas such as psychiatric nursing, midwifery, or the fast-growing areas such as telemedicine and other online applications. Conversely, freed from the constraints of the more mundane and routine healthcare delivery, physicians would also benefit assuming the role of critical care provider, the first line of defense in treatment. Doctors would also be able to further their professional positions by increased study and practice into specific medical fields, and by commanding necessary research into some of the nation's most devastating illnesses. As mentioned, many times throughout this discussion, NPs and PAs have already proven their value several times over. For years they have operated as "doctor in charge" where and whenever needed. They have been the emerging medical technician. The first responder of ambulance and rescue services. They are the attending nurse monitoring patients' progress and answering the questions regarding one's recovery and return to good health. Full autonomy, the freedom from direct oversight and scrutiny, is a small price to pay for these dedicated many.

Annotated Bibliography

Cooke, C. (August 2015). Should nurse practitioners treat patients without physician supervision? *CQ Researcher*. Retrieved from http://library.cqpress.com/cqresearcher/cqresrre2015082800

Written for the "Pro" column in *CQ Researcher*, the author outlines the impact NPs and PAs have already made in their prospective transition from supervised to autonomous, by

citing the many states in which they've practiced without supervision for decades. This supports my main claim of NP and PA autonomy.

Executive order on protecting and improving Medicare for our nation's seniors. (October 3, 2019). *The White House.* Retrieved March 28, 2020. https://www.whitehouse.gov/presidential-actions/executive-order-protecting-improving-medicare-nations-seniors/

An executive order authorized by President Trump highlights the pivotal changes necessary for "Protecting and Improving Medicare". Section 5 of this official document, is a direct proposal addressing the elimination of unspecified supervision requirements placed on NPs and PAs, giving a strong trajectory of my viewpoints in this argument.

Hanson, S. H. (February 1, 2014). VA modernizes the way physician assistants practice in four ways. *Physicians Practice.* Retrieved April 3, 2020, from https://www.physicianspractice.com/healthcare-careers/va-modernizes-way-physician-assistants-practice-four-ways

This source identified the many supporting claims of this argument that are associated with the Veterans Affairs Health Care system. The write-up offers a very strong assertion over the facts that the VA already utilizes NPs and PAs to the fullest extent of their licensing, and what positive impacts that has led to. I use several of the author's tie-ins and supporting material.

Hooker, R. S. (January 2015). Is physician assistant autonomy inevitable? *Journal of the American Academy of Physician Assistants, 28*(1), 18-20. https://doi.org/10.1097/01.JAA.0000458863.55688.a0

This source supported the claim about natural evolution guiding the progression of these two practices of NP and PA into self-sustaining entities. In this journal entry, the author also cites many other professions that have also followed this same path giving a lot of momentum to my arguments about the predictable future of these two practices. I also employ the author's keen point of view through showcasing an extensive direct quotation.

National and regional projections of supply and demand for primary care practitioners: 2013-2025. (November 2016). *U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis.* https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-national-projections2013-2025.pdf

Useful for building context in the opening paragraphs, wherein I address the concerns and projected deficit of primary care providers by year 2025, put out by the US Department of Health and Human Services. I view this as a vital piece of my main contextual argument that validates a huge overarching concern to this field's future.

Medical Economics Staff (December 25, 2018). What's ruining medicine. *Medical Economics.com*. *95*(24), 50-60. Retrieved March 28, 2020. https://www.medicaleconomics.com/business/whats-ruining-medicine-physicians-difficulty-using-ehrs

Another support for refutation, highlighting the importance of direct supervision of physicians over NPs and PAs.

Pereira, M. (January 27, 2020). A new type of healthcare practitioner: The graduate physician. *Physicians for Patient Protection.* Retrieved April 3, 2020. https://www.physiciansforpatientprotection.org/a-new-type-of-healthcare-practitioner-the-graduate-physician/?

A refutation source that I utilized when explaining the other available options to mitigating the primary care shortage.

Petzel, R.A. (December 24, 2013). Veterans Health Administration directive 1063. Utilization of physician assistants. Department of Veterans Affairs. Retrieved March 28, 2020. http://www.va.gov/oaa/directives.asp.

The actual directive of the Veterans Affairs Health Administration on practice guidelines of PAs within their facilities currently, which helps bring context to my supporting statements.

Physician assistants overview. (2020). *Scope of Practice Policy.* Retrieved March 28, 2020, from http://scopeofpracticepolicy.org/practitioners/physician-assistants/

I utilize this source for citing the current practice laws and regulations of PAs across the United States.

Speak by jan. 17 on pres. trump's executive order regarding np and pa unsupervised practice. (January 10, 2020). *Practicing Physicians of America*. Retrieved April 3, 2020.

https://practicingphysician.org/comment-on-scope-of-practice-and-pay-parity-elements-of-section-5-in-eo-of-oct-3-2019/

I utilize this source for a portion of my refutations. This organization advises the general public about the concerns surrounding educational discrepancies of NPs and PAs with physicians.

State practice environment. (2019, December 20). *American Association of Nurse Practitioners.* Retrieved March 28, 2020, from https://www.aanp.org/advocacy/state/state-practice-environment

I utilize this source for citing the current practice laws and regulations of NPs across the United States.

Timmons, E. J. (2017). The effects of expanded nurse practitioner and physician assistant scope of practice on the cost of Medicaid patient care. *Health Policy, 121*, 189-196. http://dx.doi.org/10.1016/j.healthpol.2016.12.002

I utilize this source for identifying key pieces of the source's research study that was conducted. Its outcomes support the idea that NPs and PAs do in fact have a positive impact on the underserved communities of the US (Medicaid recipients), another large supporting claim of mine.

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Cooke, C. (August 2015). Should nurse practitioners treat patients without physician supervision? *CQ Researcher*. Retrieved from http://library.cqpress.com/cqresearcher/cqresrre2015082800

Executive order on protecting and improving Medicare for our nation's seniors. (October 3, 2019). *The White House.* Retrieved March 28, 2020. https://www.whitehouse.gov/presidential-actions/executive-order-protecting-improving-medicare-nations-seniors/

Hanson, S. H. (February 1, 2014). VA modernizes the way physician assistants practice in four ways. *Physicians Practice.* Retrieved April 3, 2020, from https://www.physicianspractice.com/healthcare-careers/va-modernizes-way-physician-assistants-practice-four-ways

Hooker, R. S. (January 2015). Is physician assistant autonomy inevitable? *Journal of the American Academy of Physician Assistants, 28*(1), 18-20. https://doi.org/10.1097/01.JAA.0000458863.55688.a0

National and regional projections of supply and demand for primary care practitioners: 2013-2025. (November 2016). *U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis.* https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-national-projections2013-2025.pdf

Medical Economics Staff (December 25, 2018). What's ruining medicine. *Medical Economics.com*. *95*(24), 50-60. https://www.medicaleconomics.com/business/whats-ruining-medicine-physicians-difficulty-using-ehrs

Pereira, M. (January 27, 2020). A new type of healthcare practitioner: The graduate physician. *Physicians for Patient Protection.* Retrieved April 3, 2020. https://www.physiciansforpatientprotection.org/a-new-type-of-healthcare-practitioner-the-graduate-physician/?

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Physician assistants overview. (2020). *Scope of Practice Policy.* Retrieved March 28, 2020, from http://scopeofpracticepolicy.org/practitioners/physician-assistants/

Speak by jan. 17 on pres. trump's executive order regarding np and pa unsupervised practice. (January 10, 2020). *Practicing Physicians of America*. Retrieved April 3, 2020. https://practicingphysician.org/comment-on-scope-of-practice-and-pay-parity-elements-of-section-5-in-eo-of-oct-3-2019/

State practice environment. (2019, December 20). *American Association of Nurse Practitioners.* Retrieved March 28, 2020, from https://www.aanp.org/advocacy/state/state-practice-environment

Timmons, E. J. (2017). The effects of expanded nurse practitioner and physician assistant scope of practice on the cost of Medicaid patient care. *Health Policy, 121*, 189-196. http://dx.doi.org/10.1016/j.healthpol.2016.12.002