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STATEMENT

TO THE

SUBCOMMITTEE ON RURAL DEVELOPMENT

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

UNITED STATES SENATE

BY THE ASSOCIATION OF PHYSICIAN ASSISTANT PROGRAMS

ON

MEDICARE REIMBURSEMENT OF PHYSICIAN ASSISTANT SERVICES

Mr. Chairman and Members of the Committee:

I am Dr. Archie S. Golden, Chairman of the Government Relations Committee of The Association of Physician Assistant Programs. I am here today to offer testimony on S. 708 and the Medicare reimbursement system. I am Associate Professor and Director of The Health Associate Program at The Johns Hopkins University School of Health Services. Also, I am Associate Professor of Pediatrics at The Johns Hopkins School of Medicine and Associate Professor of Maternal and Child Health at The School of Hygiene and Public Health.

I am pleased to have this opportunity to testify on behalf of the 50 physician assistant training programs in this country. I am accompanied by Dr. Donald W. Fisher, Executive Director of the Association.

March 29, 1977 March 20 January Land, 1980 March 25, 1977 March 29, 1977 March 29

MEDICAL CARE AND THE PHYSICIAN ASSISTANT IN THE UNITED STATES

The United States Congress has, in the past six years, actively promoted the training and development of physician assistants (PAs). The Comprehensive Health Manpower Training Act of 1970 was responsible for the development of 42 physician assistant training programs whose graduates would assist primary care physicians by providing routine medical and health care services in underserved areas. The Health Professions Educational Assistance Act of 1976 authorized continuation of federal support for physician assistant programs. It should be pointed out that the U.S. Department of HEW has funded physician assistant training and research to an amount over 48 million dollars.

The Congressional support, cited above, coupled with organized medicine's recognition of the need for formally trained assistants, has been responsible for the training and development of physician assistants. In 1970, the American Medical Association defined the physician assistant as "...a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant." In 1971, Educational Essentials (1) were jointly developed by the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, the American Academy of Physician Assistants, and the American Society of Internal Medicine. Through this accreditation mechanism, more than 50 programs have been accredited to date. In 1973, the National Board of Medical Examiners administered National Certifying Examinations and continues to do so under the auspices of the National Commission on Certification of Physician's Assistants. Over 40 states

have enacted legislation providing for the practice of physician assistants with legislation currently proposed or pending in the remaining states. In 1973, the Secretary's Commission on Malpractice stated that the then growing concern over malpractice should not be a deterrent to the utilization of physician assistants.

PHYSICIAN ASSISTANT IMPACT

Economics of Care:

Educational cost data from the National Center of Health Services Research (NCHSR) on physician assistants show the education cost to be 15,100 dollars per year (2). The cost of producing a physician assistant is less than 1/4 that of preparation of a graduate physician (3). Wert's (4) data shows that a PA can provide 2.6 years of physician equivalent services before a physician who simultaneously began his medical education can begin practice. Moreover, Record (5) estimates a saving of 20,000/PA/year in an HMO setting. Peterson (6) (?) and his colleagues have shown very significant reductions in hospitalizations through the use of PA staffed ambulatory care clinics in a major V.A. Hospital.

Access to Care:

Record (7) and Hill (8), in separate studies, have shown that the outputs of primary care services are similar for both physicians and physician assistants.

Moreover, Scheffler (9) and Fisher (10) report wide distribution of PAs throughout all 50 states with a majority of PAs in primary care settings. 60 percent of PAs are in communities of less than 50,000. For example, in Oklahoma, 62.2% of program graduates are in communities of less than 25,000; in Utah, 72% of program

graduates are in communities of less than 25,000, and in Washington, 57.7% in communities of less than 20,000. Also, significant numbers of physician assistants are working in irmer city areas. The recent health manpower legislation not only authorizes funds for physician assistant training and National Health Service Corps Scholarships, but also requires that part of each Area Health Education Center include training for physician assistants or nurse practitioners. Also, it appears that the Health Resources Administration has decided that new funding for these centers will be directed at inner city urban areas.

Quality of Care:

Numerous studies, Nelson (11), Pondy (12), Henry (13), and Norbrega (14), have shown that job acceptance, as a function of quality, is highly favorable. For example, Nelson found that more than 85% of patients rate PAs as highly competent and professional, and 71% report improvement in the quality of care. Record reports no significant differences in morbidities or outcomes in primary care services delivered by MDs and PAs. More importantly, B.J. Anderson, J.D. (Staff, American Medical Association Legal Council) stated that as a result of decreased waiting time, increased accessibility to professional care and overall patient satisfaction, it appeared that the inclusion of a physician assistant in a practice was an excellent deterrent to the ever present threat of malpractice.

In sum, a review of available research shows that the physician assistant concept has been successful in addressing the three major issues confronting the nation's system for health care: (1) a reduction in cost, (2) an improvement in access, and (3) the delivery of high quality care.

THE IMPEDIMENT: MEDICARE, PART B

In spite of evidence that the physician assistant concept has been successfully addressing major national health problems, further deployment of physician assistants into underserved areas is being seriously impeded by the current Medicare Law (Title XVII (Section 1861 (s)(2)(A)), its rules and regulations.

Excerpts from the Medicare Act and Part B. Intermediary Manual reveal the problem:

Title XVIII Sec. 1861 (s): "The term 'Medical and Other Services' means any of the following items or services...(2)(A) Services and Supplies...furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physician's offices and are commonly either rendered without charge or included in the physician's bills...".

Part B Intermediary Manual, Sec. 6103 (B): "...there is no provision sunder Part B which authorizes coverage of the services of physician assistants as independent practitioners, the only basis for covering their services under Part B would be as services furnished 'incident to' a physician's professional service and one of the...requirements... for services to be covered under this provision is that they must be of kinds that are 'commonly furnished' in physicians' offices. Thus, the performance by a physician assistant of services which traditionally have been reserved to physicians cannot be covered under Part B even though all the other 'incident-to' requirements are met".

The current attention drawn to the "non-reimbursement" policy has had negative impacts in rural underserved areas of this nation. Without reimbursement for services performed by physician assistants practicing in areas with large numbers of Medicare recipients, physicians cannot afford to employ a physician assistant even though the potential benefits to patients is well recognized. Physicians have had to sharply curtail the utilization of their PAs when Medicare would not reimburse the employing physician for their services. Many program directors fear that their graduates will be forced into affluent suburban or institutional practices because the employing physician cannot be reimbursed for services safely and legally delegated. Most importantly, many Medicare recipients are having to pay for the delegated services out of their meager incomes.

In summary, in the past decade, we have seen the development of a new health profession with an accreditation mechanism which is recognized by the Office of Education (DHEW); certification mechanisms through the National Commission on Certification of Physician's Assistants and legislation in 40 states granting statutory recognition for this profession. The evidence exists that physician assistants may reduce the physician's risk of medical negligence by improving the continuity of care. Research does exist which confirms excellent patient acceptance by physicians, that physician assistants are improving access to health care by practicing in geographical areas deficient in health manpower, physician assistant productivity - within their role - is comparable to physician productivities, and that the potential for reducing the cost of health care is present with the utilization of physician assistants.

RECOMMENDATIONS

The Association of Physician Assistant Programs recommends that Title XVIII of the Social Security Act, Part B Supplemental Medical Insurance (42USC1305), and all such other medical entitlement program be amended to permit reimbursement for physician assistant services in the following way:

- (1) cost reimbursement to specific health clinics in medically underserved rural areas,
 - (2) for other underserved areas, to attract providers to practice in these areas, that reimbursement be to the physician at usual and customary rates,
 - (3) and, for all other areas, taking into consideration cost control, there would seem to be room for discussion to come up with an amenable reimbursement rate.

Also, in order to put to rest concerns relating to quality of care, fraud abuse, reimbursement should only occur when the following criteria are met:

- (1) The practice of the physician assistant is not in conflict with the laws of the state in which the services are provided.
- be provided under the <u>responsible supervision</u> of (a) licensed physician(s).

 Services of physician assistants shall include services performed regardless of whether the physician was actually present and regardless of whether the services were performed in the physician's office, or at some other site. That a physician supervise no more than two physician assistants.

(3) Physician assistants be defined as individuals who have completed an educational program for physician assistants accredited by the American Medical Association or other recognized accrediting agency and/or are holders of current certificates from the National Commission on Certification of Physician's Assistants.

We feel that it is necessary and justifiable to apply the reimbursement on a nationwide basis.

Potential Costs of Nationwide Reimbursement

We understand and share the concern of Congress about escalating health care costs. At present, we have an economist working on the question of the cost of reimbursing physician assistants nationwide and will have more exact information within two weeks and would be pleased to share that information with this committee. However, the U.S. Department of Health, Education and Welfare has developed some estimates taking into consideration physician income, number of Medicare patients, the increased intensity of care for older people and deductibles. From this they estimate the cost of Medicare reimbursement to be 1,782 dollars per physician utilizing a physician assistant or nurse practitioner per year. Since there are about 5,000 physician assistants practicing with adults, the total cost would be 8.9 million dollars. If one adds the approximately 3,000 nurse practitioners practicing with adults, the reimbursement nationwide would come to 14.3 million dollars. This is not a large amount and, in fact, it appears that close to three quarters of that amount is in reality being reimbursed today to physicians employing these new practitioners, although not covered within the Medicare rules and regulations.

Therefore, we estimate that the net increase for nationwide reimbursement would not be higher than 3.6 million dollars.

We feel that limiting reimbursement to only rural health clinics or only rural areas denies just payment to practices in many urban areas where important contributions to health care access are being made by physician assistants. In fact, there is a danger that the organizational mechanism necessary to administer such categorical reimbursement as only rural clinics or only rural areas may cost as much as the reimbursement itself.

We note that on page 58 of President Carter's FY 1978 budget revisions released on Tuesday, February 22, 1977, related to proposed Medicare legislation, there were estimated outlays of 25 million dollars which would promote the availability of primary and rural health care by extending cost reimbursement to nurse practitioners and physician assistants practicing in rural health clinics.

We feel that this amount of money would more than cover reimbursement nationwide under Medicare Part B for all physician assistants.

We recommend that S. 708 entitled "A Bill to amend title XVIII of the Social Security Act to provide payment for rural health clinic services" be adapted to provide for reimbursement for services provided by physician assistants and nurse practitioners throughout this country.

We believe that nationwide reimbursement is a necessary step not only to facilitate distribution of services and contain costs, but also to take us on the road toward equal rights for health care for all people of this country.

REFERENCES

- "Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician" American Medical Association Council on Medical Education, 1971.
- Report on 'Nurse Practitioners and Physician's Assistants Training and Deployment Study", National Center for Health Services Research, Health Resources Administration, Dept. of Health, Education and Welfare, September 30, 1976.
- Institute of Medicine, National Academy of Sciences. "The Cost of Medical Education", 1975.
- Wert, Frank, Ph.D., "Economic Comparison of M.D.:P.A. Training Costs", Discussion Paper, 1976.
- Record, Jame Cassels, et al., "Cost Effectiveness of Physician's Associates: Kaiser-Permanente Experience", Kaiser Foundation Health Services Research Center, Portland, Oregon, Unpublished Paper presented to the Health Economics Organization, American Economics Association, Dallas, Texas, 1975. Research performed under DHEW Contract No. NOI-NB-44173.
- Peterson, R.L., Pooreson, R., Fasser, C.E. and Luchi, R., "Cost Benefits of P.A. Staffed Ambulatory Clinics.", Submitted for publication, January, 1977, The P.A. Journal.
- 7. Record, Jane Casselo, et al., "Evolution of a Physician's Assistant Program in the Kaiser-Permanente System: Policies, Practice Patterns and Quality of Care", Kaiser Foundation Health Services Research, Portland, Oregon, Unpublished Paper, presented to the 4th Annual Conference on New Health Practitioners, Atlanta, Georgia, April, 1976. Research supported by DHEW Contract No. NOI-NB-44173.
- Hill, Robert F., Ph.D., et al., "The Physician's Assistant in a Rural Satellite Clinic: Report on an Evaluative Case Study of Utilization, Acceptance and Economics", The P.A. Journal, pp 165-177, Fall, 1975.
- Scheffler, Richard, M., Ph.D., "Characteristics of Physician's Assistants: A Focus on Specialty", The P.A. Journal, pp 30-41, Spring, 1975.
- 10. Fisher, Donald, Ph.D. Unpublished Paper.
- Nelson, E.G., et al., "Patient Acceptance of Physician's Assistants" JAMA, 228:1 pp 63-67, 1974.

REFERENCES (Cont.)

- Pondy, L.R., et al., "A Study of Patient Acceptance of the Physician's Assistant", Proc. of 3rd Ann. Conf. of Physician's Assistants, Duke Univ. Med. Center, Durham, North Carolina, 1970.
- Henry, R.A., 'Use of Physician's Assistants in Gilchrist County, Florida. Health Serv. Rep. 87 (8): 687-692, 1972.
- 14. Holshouser, James E., Jr., Governor of North Carolina, "Statement to the Subcommittee on Health of the Committee on Ways and Yeans, U.S. House of Representatives", presented on July 23, 1976.



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SUMMARY OF COMMENTS AND RECOMMENDATIONS

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Please note that copies of testimony provided during these hearings may be requested by writing either the Senate Subcommittee on Rural Development, Committee on Agriculture, Nutrition, and Forestry or each person individually who offered testimony on S. 708.

Dan P. Fox, P.A.-C., President-Elect American Academy of Physicians' Assistants

Mr. Fox commended the sponsors of S. 708 and the committee for considering the bill. He explained to the committee "that the cost reimbursement for rural clinics is a necessary method of assuring the continuance of delivery of needed medical and health care services to patients near such clinics," and told them that "the legislation stops short of addressing all the issues involved" and recommended the following amendments for consideration:

- (1) In subsection (j) add "with respect to physician assistant services (notwithstanding subsection (l)), payment shall be made to the supervising physician, on behalf of the beneficiary, at the usual and customary rates of reimbursement for those practices located in other medically underserved areas, as defined by the Secretary (DHEW), and at reasonable and appropriate rates of reimbursement, as defined by the Secretary (DHEW) for all other practice locations."
- (2) In subsection (aa)(2)(b) delete the words "under which provision is made for the periodic review by such physicians of" and insert therefore "to provide responsible supervision for."
- (3) In subsection (aa)(2)(c) insert the words 'responsible supervision' between the words "such" and "referral."
- (4) In subsection (aa)(3) delete all of this subsection and insert therefore "the term physician assistant means any individual who has completed an educational program for physician assistants accredited by the American Medical Association or other recognized accrediting agencies and/or holds a current valid certificate from the National Commission on Certification of Physician's Assistants, and who is legally authorized to provide any physician services, as defined in Section 1861(q), in the jurisdiction in which such services are provided."
- (5) Add a new subsection (bb) to read as follows "the term physician assistant services (notwithstanding those services covered in subsection (aa)), means such services as would otherwise be covered (under subsection (s) (2)(aa)), provided that such services are rendered under responsible supervision and that the physician assistant is legally authorized to provide any physician services, as defined in Section 1861(q) in the jurisdiction in which such services are provided."

Potential Costs of Nationwide Reimbursement

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Richard D. Warden, Assistant Secretary for Legislation-Designate Department of Health, Education and Welfare

In behalf of the Department of Health, Education and Welfare, Mr. Warden suggested the following changes be incorporated in S. 708 to strengthen its impact:

- a. Allow clinics in all underserved areas to participate;
- b. Reimburse clinics for all physician services on a cost-related basis;
- c. Retain the Medicare deductible provision for beneficiaries receiving care in clinics; and
 - d. Allow the Secretary to establish appropriate education and training standards for physician extenders recognized under this reimbursement program.

We believe clinics employing nurse practitioners and physician assistants under general physician supervision, in urban and rural underserved areas, should be eligible for Medicare cost reimbursement. Unfortunately, large numbers of Americans living in cities do not have access to a source of primary care. The Department estimates that of the 45 million people living in medically underserved areas, more than 14 million are urban residents. Given recent experiences with the so-called "Medicaid mills" in urban areas, we understand concerns about extending coverage to clinics in these settings.

It is our opinion, however, that a cost-based reimbursement system with adequate productivity standards, information disclosure requirements, and cost limits can prevent the types of fraud and abuse experienced in 'Medicaid mills!'

In closing his remarks, Dr. Wilson endorsed S. 708 and urged the committee and Congress to enact the proposed legislation. He recommended that the committee limit its reimbursement to rural areas since this would focus reimbursement on the most medically needy areas and concurrently exercise a measure of budgetary constraint; that the legislation (not regulations) emphasize that reimbursement "be provided under physician supervision with protocols, but that supervision not be prescribed as a formula for on-site attendance by the physician;" that the legislation be broadened to include quality control processes emphasizing peer and patient review; and that payment in rural areas be on a basis of cost reimbursement rather than fee-for-service.

John W. Rumyan, Jr., M.D., Professor and Chairman Department of Community Medicine, University of Termessee College of Medicine

Dr. Runyam explained to the subcommittee his experience with the Memphis and Shelby County Programs which uses physician assistants and his knowledge of other similar programs and the resulting reduction in hospital days for the elderly and patients with chronic diseases due to an emphasis on ambulatory and home care. In his testimony, Dr. Runyam recommended that "since home care is such an important extension of health services,...that its availability be considered as a criteria to qualify for Medicare reimbursement for rural clinics."

Stephen Caulfield, Assistant Director, Regional Operations United Mine Workers of America

Mr. Caulfield spoke in behalf of the United Mine Workers of America's Health and Retirement Funds which provide health benefits to coal miners and their dependents in Appalachia, the Upper Mississippi Valley and the rural West. Essentially, the Funds are a unique third-party beneficiary in that they control expressed concern that S. 708 in establishing different reimbursement mechanisms for physician assistants in rural and nonrural areas that two standards of care may result and unwittingly create the same kind of disincentive to rural practice for physician assistants that has been created for physicians under the 'usual and customary' regulations of Medicare." United Mine Workersof America supports, according to Mr. Caulfield, cost-base reimbursement and prospective payments. Strong support was also voiced for "regular review by the supervising physician, utilization review procedures, certification of the physician assistant, and explicit arrangements between the hospital and the clinic."

The United Mine Workers of America has been a supporter of the physician assistant concept, however, it is firmly opposed to the concept of independent practice and openly expressed its dissatisfaction with the American Nurses' Association's suggestion that "the relationship between the physician and the nurse practitioner should be collegial, not supervisory."

Ralph Borsodi, Economist National Retired Teachers Association and the American Association of Retired Person

Mr. Borsodi testifed that "because of the relative paucity of physicians, sometimes the only care which may be available is that provided by physician extenders in rural clincis. Yet, the Medicare law does not recognize these providers for purposes of reimbursement. Thus, a situation has been created in which a large group of beneficiaries is contributing to the costs of the program without having equal access to all its benefits. It is our position that steps should be taken to correct this inequity by providing reimbursement to clinics

which offer care provided by physician extenders." NRTA/AARP suggested to the subcommittee that it consider prospective reimbursement since it 'provides a greater opportunity for providers and payers to project outlays more accurately." Mr. Borsodi further commented upon the need for consistency in our nation's health policy: "Since public monies are currently being used to support the training of physician extenders, it only follows that government programs such as Medicare should recognize this fact by reimbursing the services provided by these extenders."

Edgar T. Beddingfield, Jr., M.D., Chairman, Council on Legislation American Medical Association

The American Medical Association summarized its testimony as follows:

If the Medicare program is to recognize payment for services of physician extenders, discrimination should not be created against the fundamental situation out of which the physician extender movement developed. The basic concepts must include (1) proper supervision and control by the physician of a properly trained physician extender, (2) responsibility in the physician for the services as evidenced by the billing for the services in the name of the physician, and (3) compliance with state requirements. If these are adhered to, the use of physician assistants would be encouraged in shortage areas. To this end, a simple amendment to the Medicare law giving recognition to the true nature of the extender's service would be more appropriate than creating the Medicare-defined "rural health clinic" in order to recognize the extender's service. Accordingly, a simple amendment to include the extender's service as an integral part of the physician's service would foster the development of the original concept and help provide quality care in rural areas.

Leo J. Gehrig, M.D., Senior Vice President American Hospital Association

Recommendations made by Dr. Gehrig to the subcommittee included: "that payment for services provided by rural clinics be provided...on the basis of reasonable costs related to providing such services."

- The term "nonphysician primary health care provider" should be substituted for "physician extender" in the proposed section 1861(aa)(3) of the bill;
- To assure that 'nonphysician primary health care providers' meet necessary training and experience qualifications, they should be restricted in the proposed section 1861(aa)(3) to individuals who:
 - are licensed by the state in which they provide services or are in compliance with state regulatory requirements that define the limits of their practice; and

- hold credentials from a nationally recognized organization, such as the National Commission on Certification of Physician's Assistants, the American Nurses' Association, or the National Association of Pediatric Nurse Practitioners;
- To be consistent with payment principles of the Medicare program, payments for services under S. 708 should be provided on the basis of reasonable costs related to providing such services, as defined in section 1861(v)(1)(A) of the Social Security Act;
- 4. Nonphysician primary health care providers in hospital-based or operated clinics must be subject to the rules, regulations, and procedures of the institution with respect to the scope of services provided by such individuals; and
- An evaluation of the quality of services as provided under the requirements of S. 708 should be conducted within one year of enactment of the bill into law.

Anne Zimmerman, R.N., President American Nurses' Association

Ms. Zimmerman shared with the subcommittee the American Mirses' Association's definition of a nurse practitioner as "an independent licensed health care professional responsible and legally accountable to the consumer. The nurse practitioner is expected to make complex professional judgments on a wide range of patient care problems. These judgments can and often do mean the difference between life and death. Like other health care professionals, the nurse practitioner must carry personal liability insurance." She further stated, "We believe it is unnecessary for the bill to make reference to 'supervisory physician' as it applies to nurses. Integral differences between nurse practitioners and physician assistants, by definition, preparation and legal status...are the basis for the...proposed change." In closing, the American Nurses' Association requested that the proposed law be "explicit that the service provided by nursing in rural clinics is not that of a second rate physician where second rate is better than none, but that, within this shared area of practice, nurses have the same competence as any other professional who has traditionally operated in that area."