



Maine Board of Licensure in Medicine
137 State House Station
161 Capital Street
Augusta, ME 04333-0143

Monday, August 3, 2020

Dear Board members,

On behalf of the Maine Association of Psychiatric Physicians (MAPP) and Physicians for Patient Protection (PPP; a 501c organization comprised of physicians focused on patient safety and scope of practice issues), we are writing to submit comments on the amendment draft to Board Rule Chapter 2. We appreciate the invitation for comments.

As the Maine Board of Licensure in Medicine (BOLIM) may agree, there are numerous potentially unsafe aspects of this law. However, now that it is in the rule-making process, we have a need to protect the public from engagement with unqualified health care practitioners. Four areas of concern we would like to address as opportunities in this rule-making process are: scope of practice, truth in advertising, collaboration, and pay parity.

Scope of Practice

Point (8) on page 6 of the BOLIM draft under “Uniform Requirements for Full License” requires for licensure that a physician assistant (PA) “demonstrates current clinical competence as required by this law.” (This requirement is also found on page 11 under license reinstatement.) Clinical competence is not explicitly defined under the law, per se, but on page 15, under Uniform Scope of Practice for Physician Assistants, PAs are granted the authority to provide “any medical service for which they physician assistant has been prepared by education, training, and experience and is competent to perform. The scope of practice of a physician assistant is determined by the practice setting.”

The scope of practice of physicians is determined by completion of a Liaison Committee on Medical Education (LCME)-accredited medical school, followed by completion an Accreditation Council of Graduate Medical Education (ACGME)-approved residency program. This nearly-decades-long process is most often followed by passing multi-day specialty exams to earn “board-certification” in one’s American Board of Medical Subspecialties (ABMS) specialty as determined by the 3-7 year-long residency, with or without an additional 1 to 3-year long fellowship. This process ensures rigorous standardization of skills and includes multiple overlapping determinants of competence.

No similar oversight in PA training exists. The draft appears to show that the BOLIM has opted to forego the need for this rigorous determination of safe scope of practice and opt instead to allow PAs to claim expertise based on practice location or whatever training and education the PA decides is sufficient. Under this system, a PA could legally claim to be a “specialist” in dermatology after working for a few weeks in a dermatology

practice, while a physician with many years more training in dermatology is legally barred from such claims. The confusion created by this double standard communicates to patients that the training of a PA “specialist” exceeds that of a physician, and yet this deception is legal on a state level. Likewise, a PA could decide he/she is competent to perform a thoracentesis after watching one in the emergency department. This PA with no formal training in this procedure could decide to perform this procedure on a patient,, who has no idea of the lack of training of this clinician and the associated. No true informed-consent is possible, as the risks of the procedure being performed by an untrained individual are additive to the inherent risks of the procedure. Relying on the employer to ensure and/or provide the training and oversight for PAs’ scope of practice places the responsibility on to employers, who practice in a business model, not in an altruistic one of educator.

The BOLIM does not determine scope of practice for physicians through the licensing process because there is already a system in place that determines physician scope of practice. However, since a similar system is not in place for PAs, how is the BOLIM going to protect public safety by ensuring PAs are competent to perform in the scope of practice they self-declare? If there is no answer, perhaps this needs to be carefully established as part of the rule-making process. The speed of the law-making seems to demand more from the medical system than currently exists to determine scope of practice of PAs in a manner commensurate with public safety.

In the absence of an existing system to determine the bounds of PA scope of practice, two options are:

1. to disallow PA claims of specialization based on practice location; see also “Truth in Advertising” below
2. to require consultation with physicians that occurs in person, on-site while practicing, to determine and approve scope of practice. Due to their rigorous standardization of education, physicians *are* in a position to determine safe scope of practice by PAs on a case-by-case basis. This suggestion is different than the on-paper approval provided by BOLIM staff, who are removed from observing the actual provision of care, that is being proposed in the current draft. Furthermore, this suggestion is *different* from “collaboration” (which suggest equal but complementary expertise between a physician and a PA) or “supervision” (which is not permitted by the statute). The PA would be legally liable for his or her own work, but would be required by the BOLIM to document external validation of safety to function safely within a defined scope of practice. We understand that the BOLIM has attempted to achieve this via collaboration agreements, which we believe does not accomplish one of the stated goals of LD1660 of removing physician liability from PAs’ practice. We address this specific issue in greater detail in the section “Collaboration” below.
- 3.

Truth in Advertising

As discussed above, the draft proposal as written allows PAs to define their own scope of practice. This option not only lacks safeguards for patient safety, but also allows misleading self-promotion on specialization. The AMA performed a longitudinal Truth in Advertising survey that found that 61% of patients thought that PAs with a doctorate of medicine science were physicians (https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/tia-survey_0.pdf). We believe as regulators of both physician and PA practice, the BOLIM is in a unique position to help clear up the confusion and thereby empower them to make autonomous, educated decisions about healthcare purchasing. In the Truth in Advertising campaign stated above, 91% of respondents said that a physician’s years of medical education and training are vital to optimal patient care. PAs should not be allowed to claim to be a “dermatology specialist” simply because they work in a dermatology office, which implies to patients that they have more experience in dermatology than the patient’s internist. Additionally, a PA with a medical science doctorate who passed the National

Commission on Certification of Physician Assistants (NCCPA) certification program should not be allowed to claim she is a “board-certified family medicine doctor.” These claims are misleading and dangerous. We propose that the rule-making process include truth in advertising language that includes, but is not limited to, requirements for disclosure of title to every patient, as well as require PAs to explicitly correct patients who refer to them as “doctor.”

Collaboration

The term collaboration is used when discussing work among nurses and physicians because they represent different professions. In contrast, physicians and physician assistants both belong to the profession of medicine with the distinction being that PAs complete significantly less training. As a result, when a physician and a PA work together on a case, that physician is either supervising the PA (e.g. the physician shares responsibility for the patient) or that physician is consulting (e.g. not primarily responsible for the patient). If a physician is involved in a case with a PA in a supervisory (or “collaboration,” as per the draft) manner, the physician will be held liable because physicians have more training. Simply stating that PAs are liable for their own mistakes, as the draft says, does not make it so. Changing the language to “consultation” (e.g. not sharing responsibility) can help, as can requiring that PAs hold the same malpractice as physicians. Given their lesser training, PAs are actually more likely to commit malpractice than physicians and should carry more, not less, malpractice insurance than physicians.

Thus, as far as rule-making is concerned, we propose that the term “collaboration” be updated to “consultation” to more accurately reflect the purpose of the bill to establish independent PA practice, which also requires the transition of liability in a way that will be legally valid. The consultation with physicians can be both for establishment of scope of practice, as well as for that period prior to a PA achieving 4,000 clinical hours.

We also would like to comment on the omission of a consultation (“collaborative”) agreement requirement for PAs hired by facilities that credential them. We believe this is a dangerous oversight in patient safety that assumes employers provide physician staff to meaningfully review their work, which is widely known to not occur. Furthermore, it continues to make physicians liable for the work done by PAs at those institutions. I do not see any justifiable reason to exclude inexperienced PAs hired by facilities from the consultation (“collaborative”) agreement proposed by the Board. This is an issue of ensuring ongoing supervision to ensure safety in licensure and we do not believe oversight of that can safely be left to employers whose goal is maximum productivity of employees.

Pay Parity

We based our comments on the BOLIM draft, but do want to say that a paragraph in the osteopathic version appears to require pay parity for PAs. We do not see a similar statement in the BOLIM version.

Various interests have promoted the false narrative that a generic “health care provider” provides uniform medical services independent of the training of the “provider.” This falsity is actualized by an insurance industry coding system that distinguishes the care of other specialties, such as occupational therapists, social workers, audiologists, chiropractors, and nutritionists, but makes no similar distinction between the nature of the service provided by physicians, nurse practitioners, and PAs, other than by a slight *percentage* reduction for non-physician providers (NPPs).

Pay parity laws gloss over the fact that physicians, NPs, and PAs, actually provide different medical services based on their expertise. The only public agencies that truly understand the differences in training and thus can protect the public from a false belief in equivalency are the medical boards. For the osteopathic medical board to promote pay parity is to equate the training and education of PAs with that of physicians. The downstream consequences of this false equivalency in the business-of-medicine model would be devastating to patient safety as lower-cost PAs are hired to provide “the same” medical care as physicians, when in fact the care is not the same. Furthermore, patients lose the right to see a physician when HMOs fill their panels with PAs and insist that rather than see a family practice physician as a PCP, the patient MUST see a PA who works in family practice because they provide “the same” medical service.

Our concern with the draft as it stands is that rather than permit a specific type of clinician to work independently, it functionally gives PAs a license to practice medicine in the same capacity as physicians, without them actually completing the training necessary to achieve that level of competence. The practice of medicine would thus be largely performed by people without medical degrees, while the public continues to be lost in confusion about the actual training and oversight of these clinicians, which they understandably assume others (the employers, the BOLIM) are doing.

In closing, thank you for taking the time to read these comments.

Sincerely,

Maine Association of Psychiatric Physicians

Physicians for Patient Protection