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LETTER TO THE EDITOR

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Reply to: *comment on increased reliance on physician assistants: an access-quality tradeoff?*

Bhavneet Walia[a], Harshdeep Banga[b] and David Larsen[a]

[a]Syracuse University; [b]SUNY ESF

We thank Cawley, Hooker, and Nicholson [1] for engagement with our work [Walia et al. [2]], and herein provide a response. Their comment continues discussion of a vitally important topic in health care: the optimal role and scope of Medical Doctors (MDs) and Physician Assistants (PAs) in healthcare systems. This continued, fact-based discussion has potential to improve healthcare quality for patients at each level of healthcare.

Cawley, Hooker, and Nicholson [1] find fault with our understanding of Brock et al. [3], which we cite in our original study. In characterizing Brock et al.'s work, we accepted the abstract, which states, 'Diagnosis-related malpractice allegations varied by provider type, with physicians having significantly fewer reports (31.9%) than PAs (52.8%) or NPs (40.6%) over the observation period.' After publication of our article, we were made aware by Cawley, Hooker, and Nicholson that, contrary to this abstract summary, we needed to calculate for ourselves the relative frequency of diagnosis-related malpractice allegations from data presented in Table 4 of Brock et al. It appears that a main implication in the body of Brock et al. opposes the wording of the abstract in finding that malpractice allegations were lower among PAs than physicians. We encourage authors to seek a revision of Brock et al. to clarify their findings.

So what does this mean for our findings? The results from Brock et al. are discordant with the results from Yawn and Wollan [4], which we have also cited in favor of our suggestion that increasing PAs will lead to an access-quality tradeoff. Another study by Lozada et al. [5] finds that the average sampled Nurse Practitioner or Physician Assistant overprescribes opioids at more than twice the rate of the average sampled MD, where prescription is, of course, a primary treatment dimension of care that follows diagnosis. When contextualizing the original results of Brock et al. and the comments of Cawley, Hooker, and Nicholson, it is further important to note that some US states (e.g., Arizona) treat supervising physicians as liable for PA malpractice. The US National Practitioner Data Bank data upon which Brock et al. rely reports medical malpractice payer incidence data and is therefore subject to bias (e.g., whenever a PA commits malpractice but the supervising physician is liable). This potentially substantial source of bias was not noted nor considered in the research design of Brock et al. and, further, was not noted by Cawley, Hooker, and Nicholson. A more appropriate research design for Brock et al. would have been to separate states according to whether supervising physicians are liable (payers) for PA medical malpractice prior to analysis. Further research on malpractice allegations is apparently needed, however. We encourage interested parties, including PA advocacy groups, to fund objective scientists to conduct such research.

We wish to emphasize that the presence of a tradeoff between PAs and MDs does not serve to paint PAs (or MDs) in a harsh light. Rather, the presence of a tradeoff suggests that each labor group has relative strengths and relative weaknesses. When comparing any two labor groups, we expect to observe tradeoffs. If there were no tradeoffs between reliance on PAs and reliance on MDs, this would suggest that one group is superior to the other in all respects. If this was the case, then we would expect only one group to be hired and the other group to phase out of the labor market. The present growth of *both* PAs *and* MDs in US healthcare labor markets therefore implies the existence of tradeoffs between the two groups. The comment piece by Cawley, Hooker, and Nicholson [1] focuses on one side of the tradeoff and exclusively defends against the existence of that side of the tradeoff. However, the

CONTACT Bhavneet Walia bwalia@syr.edu Syracuse University

comment fully omits mention of the equally important conclusion from Walia et al. that the present degree of reliance on MDs exacerbates healthcare access problems in the US. Indeed, the access-quality tradeoff discussed in Walia et al. equally implies that increased reliance upon PAs will *improve* US healthcare access. As a thought experiment, we encourage the reader to consider the following:

If it were the case that PAs improve healthcare access and either improve or maintain the same level of healthcare quality, in all respects, as MDs, what would prevent U.S. healthcare regulations and organizations from moving solely toward PAs (away from MDs) for care in the long run?

In addition to the pivotal error discussed in the abstract summary of Brock et al., we also note that the authors of the comment have a significant conflict of interest. Rather than constituting an academic discussion regarding objective evidence, their comment was prepared by a physician assistant advocacy group. We therefore have responded in good faith, while also noting that we have zero conflicts of interest and only seek to understand and communicate what we discover.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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