AMERICAN ACADEMY of DERMATOLOGY | ASSOCIATION

1445 New York Ave., NW, Suite 800
Washington, DC 20005-2134

MAIN: (202) 842-3555
FAX: (202) 842-4355
www.aad.org

April 30, 2019

The Honorable Fred H. Mills, Jr.
Chair, Senate Committee on Health and Welfare
State of Louisiana
P.O. Box 94183
Baton Rouge, LA 70804

Dear Chairman Mills,

On behalf of the nearly 14,000 U.S.-based members of the American Academy of Dermatology Association ("Academy") and the Louisiana Dermatological Society (LDS), we strongly oppose legislation that would eliminate the formal supervisory relationship between physicians and physician assistants. This model of care contradicts our organizations' position that dermatology patients benefit from physician-led team-based care.[1] We remain committed to working together with physician assistants as important members of the care team, and for the reasons set forth below, we urge members of the Senate Committee on Health and Welfare to oppose SB 166.

The best and most effective care occurs when a team of health care professionals with complementary—not interchangeable—skills work together. Dermatologists and physician assistants have long worked together to meet their patients' needs. This is because the physician-led team approach to care works. SB 166 seeks to jeopardize this success by eliminating the physician's role as the leader of team-based care, which will lead to fragmented care.

[1] AAD *Position Statement on the Practice of Dermatology: Protecting and Preserving Patient Safety and Quality Care,* https://www.aad.org/Forms/Policies/Uploads/PS/PS-Practice%20of%20Dermatology-Protecting%20Preserving%20Patient%20Safety%20Quality%20Care.pdf

This is antithetical to the team-based approach and new health care models, such as accountable care organizations, that require increased teamwork among physicians, nurse practitioners, physician assistants, and other providers of care. Efforts to disassemble the physician-physician assistant relationship will further compartmentalize the delivery of health care. The optimal way to provide dermatologic care is under the direction of a board-certified dermatologist, who retains ultimate responsibility for patient care and tasks delegated to care team members. The dermatologist also remains responsible for ensuring that all delegated activities are within the scope of each care team member's training and level of experience.

The education and training of a physician assistant falls significantly short of the education and training of a physician. Board-certified dermatologists diagnose and treat over 3,000 different diseases and conditions. Dermatologists see patients of all ages, from newborns to the elderly. A board-certified dermatologist undertakes a minimum of 8 years of exhaustive medical education and training (4 years of medical school, 1 year of internship, 3 years (minimum) of dermatology residency), during which they complete 12,000 to 16,000 hours of direct patient care, before they can practice independently.

Medical students who attend schools accredited by the Liaison Committee on Medical Education are required to care for patients in both inpatient and outpatient settings in the following clinical rotations: family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery.[2] Similarly, students at colleges of osteopathic medicine that are accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation must receive education in the following clinical disciplines: internal medicine, obstetrics/gynecology, pediatrics, family practice, surgery, psychiatry, radiology, preventive medicine, and public health.[3] All medical students must also select a number of specialty elective rotations to round out their exposure to the branches of medicine, ensuring a broad and comprehensive medical knowledge base upon which they build by choosing an area of practice specialization for graduate medical education, commonly known as residency.

In stark contrast, physician assistants complete a 26-month physician assistant program followed by 2,000 hours of clinical rotations, which emphasize primary care in ambulatory clinics, physician offices and acute or long-term care facilities.[4] Rotations could also include family medicine, internal medicine, obstetrics and gynecology,

---

[2] Web, Liaison Committee on Medical Education (LCME). LCME Accreditation Standards with annotations.*www.lcme.org*
[3] Web, https://www.aacom.org/docs/default-source/cib/aacom-cib-2019-all-web.pdf?sfvrsn=95e22597_8
[4] https://www.aapa.org/what-is-a-pa/#tabs-2-how-are-pas-educated-and-trained

pediatrics, general surgery, emergency medicine, and psychiatry.[5] Unlike physicians, physician assistants are not required to complete a residency program. Physician assistants who elect to practice in dermatology are trained in the clinic by dermatologists.[6] There are no uniform training requirements in such setting. Training requirements, including length of time, varies from practice to practice.[7]

By any measure, the differences in training are significant. Given the wide array of challenges and complexity that confront health care practitioners, particularly as the population ages, physicians' additional training and expertise allows them to substantively reduce the incidence of complications and to recognize and treat complications appropriately should it occur.

Studies demonstrate differences in patient outcome and utilization rates. New research shows that dermatologists are more effective than physician assistants in diagnosing skin cancer. Researchers examined data from 33,647 skin cancer screenings in 20,270 patients at University of Pittsburgh Medical Center-affiliated offices from January 2011 through December 2015. Compared to dermatologists, physician assistants needed to perform more biopsies to detect melanoma and nonmelanoma skin cancer. To diagnose one case of melanoma, the number needed to biopsy was 39.4 for physician assistants and 25.4 for dermatologists. To diagnose one case of skin cancer, the number needed to biopsy was 3.9 for physician assistants and 3.3 for dermatologists.[8]

Dermatologists were more likely than physician assistants to diagnose noninvasive melanoma, which the authors note is more difficult to identify than invasive melanoma. According to the authors, early detection and treatment of noninvasive melanoma can result in improved patient outcomes and lower treatment costs.

A 2015 study from the University of Wisconsin comparing malignancy rate of biopsies performed by dermatologists versus non-physicians suggests that an increased use of biopsies may increase the morbidity and cost of care provided when provided by non-physicians.[9] Removing physician supervision of physician assistants would lead to misdiagnoses, adverse events, and increased health care costs This is a public health hazard that will be aggravated by this legislation.

---

[5] https://www.aapa.org/wp-content/uploads/2016/12/Issue_Brief_PA_Education.pdf.
[6] Web, The Society of Dermatology Physician Assistants, http://hireadermpa.com/dermpa-training/
[7] I*d.*
[8] Matsumoto, M. et al (2018, May). Estimating the cost of Skin Cancer Detection by Dermatology Providers in a Large Health Care System. JAMA Dermatol. May 2018 Volume 154, Number 5.
[9] Bennett, D., Xu, Y (2015, August). Biopsy Use in Skin Cancer Diagnosis: Comparing Dermatology Physicians and Advanced Practice Professionals, JAMA Dermatol. August 2015 Volume 151, Number 8.

The public supports physician-led team-based care. As members of the health care delivery system, it is a common goal of both physicians and physician assistants to ensure that patients receive the highest quality care. We believe this is achieved when health care is delivered by a physician-led team; a model that is also supported by the public. According to four nationwide surveys, 84% of respondents prefer a physician to have primary responsibility for diagnosing and managing their health care and 91% of respondents said that a physician's years of medical education and training are vital to optimal patient care, especially in the event of a complication or medical emergency.[10]

There is a wide spectrum of training and expertise among health care professionals. In a clinical setting, it is often impossible for patients to know whether the person providing their care is a physician, nurse, physician assistant, pharmacist, dentist, or dental hygienist. This creates a great deal of confusion for individuals receiving health care. Our patients have the right to know the credentials and the level of training of that person making the important medical diagnosis, pushing medications into an intravenous line, using a scalpel, or pointing a laser at their face, torso, arms, or legs.

Additionally, the nationwide surveys confirm increasing patient confusion regarding the many types of health care providers - including physicians, nurses, physician assistants, technicians and other varied providers. Nearly 80% of those surveyed support state legislation requiring all health care advertising materials to clearly designate the level of education, skills and training of all health care professionals promoting their services. The survey revealed:

- 47 percent of patients incorrectly believe an optometrist is a medical doctor;
- 39 percent of patients believe a nurse with a "doctor of nursing practice" degree is a medical doctor;
- 44 percent of patients believe it is difficult to identify who is a licensed medical doctor and who is not by reading what services they offer, their title and other licensing credentials in advertising or other marketing materials.

Existing law does not prevent physician assistants from currently practicing in rural and underserved areas. Existing state law does not set geographic boundaries nor is there evidence that eliminating the supervisory relationship will improve access to care. This is further illustrated by the geographic mapping initiative of the American Medical Association, which demonstrates that non-physician health care providers are not located in rural or underserved areas, but rather, are concentrated in the same geographic areas as physicians.

[10] Surveys of nearly 1,000 adults on behalf of the AMA Scope of Practice Partnership were conducted in 2008, 2010, 2012, and 2018.

As physicians, our number one priority is the health and welfare of our patients. The Academy and LDS appreciate the opportunity to provide written comments on this important public health issue. We respectfully urge you to carefully consider the ramifications of SB 166, which suggests physician and physician assistants are equivalent in training and education. We remain committed to providing high quality care and serving the best interests of our patients through physician-led team-based care. For further information, please contact Lisa Albany, director of state policy for the American Academy of Dermatology Association, at **LAlbany@aad.org** or (202) 842-3555.

Sincerely,

George J. Hruza, MD, MBA, FAAD
President
American Academy of Dermatology Association

Erik Soine, MD, FAAD
President
Louisiana Dermatological Society