Physician Assistants, Nurse Practitioners, and Community Health Centers under the Affordable Care Act

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Critical medical anthropology has extensively critiqued biomedicine's hegemonic structure that places doctors in control of knowledge and power and casts patients as depersonalized recipients of treatment (not care). Yet in the United States, an increase in collaborative models of health care impacts not only the types of providers patients see for care but also how that care is delivered. Under the Patient Protection and Affordable Care Act (ACA), community health centers (CHCs) are at the center of the expansion of accessible and high-value primary health care. It is estimated that CHCs will add 15,000 new providers to their staffs by 2015, and most will be non-physician providers, such as physician assistants (PAs) and nurse practitioners (NPs). In this paper, I seek to understand the role of PAs and NPs in delivering health care to medically underserved populations. In doing so, I explore beyond the provider-patient relationship to include the relationships *within* collaborative care teams and relationships between the clinic and the community. Analysis of these multiple complex relationships among different types of providers, patients, and communities help us to understand how relationship dynamics and trust influence patient care and outcomes in this type of health care setting.

Key words: United States health care, physician assistants, nurse practitioners, community health centers, roles

Introduction

Medical anthropology has a rich literature on the study of biomedicine and physician-patient relationships within mainstream medicine. However, with the exception of midwifery and complementary and alternative medicine (CAM), very little has been discussed about the role of other health professionals in the delivering of health care in the United States and the relationships between those providers and patients. In the following sections, I briefly review the literature on doctor-patient relationships within biomedicine and aim to move the discussion beyond a critique of the hegemonic power relations between provider and patient. My goal is to analyze the expanding care that physician assistants (PAs) and nurse practitioners (NPs) are delivering within the context of a changing health care system in the United States. The research setting is community health centers (CHCs), which have been expanded under the Affordable Care Act and are intended to strengthen the country's primary care safety net. This exploration includes not only provider-patient relationships but also the relationships *within* collaborative care teams and relationships between the clinic and the community. Analysis of multiple relationships among providers, patients, and communities help us understand how relationship dynamics and trust influence patient care and outcomes in this type of health care setting. I argue that within most CHCs, which serve the medically underserved, the roles of PAs and NPs (PA/NPs) extend beyond clinical skills and include a holistic approach to patient care that incorporates the life-worlds of their clients.

Research Background

I have been researching the profession of physician assistants (PAs) for 14 years, with projects on PA education and training, PA retention in rural settings, PA roles in rural health, PA relationships with patients and the communities, and most recently the role of PAs in community health centers and serving the medical underserved (Henry and Hooker 2007, 2008, 2014; Henry, Hooker, and Statler 2002; Henry, Hooker, and Yates 2011). This paper combines analysis from two projects—one investigating the role of PAs in community health centers and the other PA retention in rural community health centers (CHCs).

In the first project, one of the main objectives was to holistically investigate CHC clinic culture and understand how the culture of the clinic influences the roles of PAs. Although this project was initially focused on the roles of PAs in serving the medically underserved, it became quickly evident that PAs and NPs were interchangeable in their roles at CHCs (Henry and Hooker 2014). In fact, one physician interviewed did not know there was a PA working at the clinic. He thought they only employed NPs. I conducted 180 hours of ethnographic clinic observations, 125 patient surveys, and 49 semi-structured interviews with the entire medical staff of 10 CHCs in Texas. This included physicians (n=9), PAs (n=10), NPs (n=4), nurses (n=16), and medical assistants (n=10). The medical staff reported few differences in the performance roles of PAs and NPs. All clinics included both PAs and NPs in employment announcements and considered them to have equal qualifications for the purposes of staffing the clinics. Therefore, my analysis (and policy discussion) includes NPs to extend the discussion more broadly. I use this research project to support my discussion of provider-patient relationships, relationships within collaborative care teams in community health centers, the role of PA/NPs in CHCs, and provider-community relationships in CHCs.

In the second project, my main objective was to understand what influences the retention of physician assistants in rural CHCs. Selection criteria included PAs who worked autonomously in rural clinics (in towns with populations under 5,000) with no more than eight hours per week with the supervising physician, who were employed as the sole care provider in the clinic, who had worked for more than 24 months at the same clinic, and where the clinic was the only health care option in a 25-mile radius. I conducted 220 hours of ethnographic observations in clinics and around towns, eight semi-structured interviews with PAs, eight semi-structured interviews with town officials on issues of town health care (history and future), and eight focus groups with community members. A major theme that emerged was how retention related to relationships between PAs, patients, and the surrounding community. I use this research project to support my discussion of provider-patient relationships and provider-community relationships in CHCs. Provider relationships within collaborative care teams were not a focus of this research since PAs were practicing autonomously in satellite clinics. It is noteworthy, however, that PAs were very satisfied with the short amount of time spent with supervising physicians and chose to practice in remote, satellite locations because they had more autonomy than in other clinics.

Physician-Patient Relationships

The social sciences, and medical anthropology in particular, have studied the ways in which physician-patient relationships are created and enacted along with the subsequent implications for patient health and well-being (Davis-Floyd and St. John 1998; Gaines and Hahn 1985). Research shows that problematic physician-patient relationships within biomedicine have resulted in an increase of patient noncom-

pliance, miscommunications, or dangerous cultural clashes (Grimen 2009; Hunt and Arar 2001; Lazarus 1988). This is evidenced through the body of knowledge documenting how racial, economic, and educational disparities shape the physician-patient relationship (Fiscella et al. 2000).

The role of language in physician-patient relationships is also well researched (Duranti 2001; Gumperz 2001; Zimmerman and Boden 1991). Cultural and language barriers that non-English and English speaking patients alike face when negotiating unfamiliar medical practices and terminology can pose challenges (Rouse 2010). Conflicts are commonly created through inadequate translations and competing cultural conceptions of illness, resulting in a patient's unwillingness or inability to submit to a physician's orders (Ferzacca 2000; Rouse 2010; Taylor 2003; Trostle 1988). Further linguistic studies have been situated in Arthur Kleinman's (1980) cognitive concept of "explanatory models," which outlines the differing ways doctors and patients frame their understanding. This is to say, doctors seek to identify the etiology of an illness and typically communicate their knowledge within these biological boundaries. Patients, however, seek to improve their "lifeworld," processing the given information in terms of their experiences, responsibilities, and cultural contexts (Abbe 2011; Barry et al. 2001; Hunt and Arar 2001; Mishler 1984). In the event that the two models fail to overlap, the relationship can become ineffectual.

Research has shown that the foundation of the physician-patient relationship is strongly situated as a power imbalance, with the physician maintaining the position of authority over the patient (Grimen 2009; Rouse 2010; Singer and Baer 2007; Taussig 1980). This has been explored through numerous lenses over the last several decades. Michel Foucault's (1972, 1994) concept of power lends itself to understanding the ways in which this power relationship is created and reproduced through systems, institutions, and even language. Critical medical anthropology (CMA) has been commonly applied to the study of physician-patient relationships as it widens the scope of influencing factors beyond the micro purview of the traditional explanatory models (Lazarus 1988; Singer 2004; Singer and Baer 2007). CMA instead seeks to understand how macro forces like political economy, social identity, power, inequality, and poverty are embodied and expressed in these relationships (Abbe 2011; Baer, Singer, and Johnsen 1986; Singer 2004; Singer and Baer 2007). Take for instance, the role of risk and trust between physician and patient. Years of advanced education designates authoritative power to a physician, placing a patient into structural inferiority in comparison (Foucault 1972; Grimen 2009; Jordan 1993, 1997). The patient, limited in their knowledge and power, may be obliged to trust the physician and assume the risks associated with their judgment. I aim to move the discussion beyond a critique of the hegemonic power relations between provider and patient towards an analysis of the expanding care PAs and NPs are delivering within the context of a changing health care system in the United States.

The Expansion of Community Health Centers under the Affordable Care Act

The Community Health Center (CHC) program was launched in 1965 with the intent to address the basic health care needs of children in the newly established Head Start program in Alabama and Mississippi (Hawkins and Groves 2011). Increased investments in CHCs began with the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA funding provided substantial support and infrastructure improvements for the eventual health care reform and Affordable Care Act (ACA) of 2011, which has the potential to drastically change how CHCs deliver health care to millions of people across the country. The expansion of the CHC program is intended to strengthen the country's primary care safety net, which consists of clinics and hospitals that provide preventive or chronic care for free or on a sliding payment scale for the medical underserved or those without insurance. As of 2011, the CHC program expanded care for over 20 million people of all ages (NACHC 2011) and is expected to more than double to 40 million by 2015 (Hawkins and Groves 2011). By 2015, it is expected that CHCs will serve two out of every three people living in poverty and reach one-third of Americans previously classified as living in "medically disenfranchised" areas or areas with too few primary care providers (Andrulis and Siddiqui 2011). To meet patient demand, there is also an expanding health care workforce. The total number of full-time positions in CHCs increased from 113,000 in 2009 to 156,000 in 2013 (HSRA 2013).

Providers in an Evolving Health Care System

Access to health care in the United States depends on a sufficient supply and distribution of primary care providers. The United States will face a shortage and inadequate distribution of physicians and other health care providers in primary care settings by 2020 (AAMC 2008; Hill 2012). Though these shortages are a challenge, they also present new opportunities for physician-led care teams. In this model, teams of physicians, physician assistants, and nurse practitioners collaborate and cooperate to provide the best care possible for patients (Doherty and Crowley 2013).

Health professionals other than physicians have a large role to play in the expansion of CHCs to provide high-quality, coordinated clinic care. According to Hing, Hooker, and Ashman (2011), community health centers are twice as likely to use physician assistants and nurse practitioners when compared to other primary care providers. Within community health centers, physician assistants and nurse practitioners make up 18 percent of the clinicians, with physicians making up 29 percent and certified nurse midwives, dentists, pharmacy personnel, and nurses making up the other 53 percent (NACHC 2013). This collaborative physician-led care model is aimed at improving access to care, improving patient outcomes, and reducing health disparities in underserved communities (National Research Council 2001).

The PA and the NP professions were developed in the 1960s to relieve the nationwide shortage of primary care professionals and to increase access to health care for people in underserved areas (Larson et al. 1999; Krein 1997; Mittman, Cawley, and Fenn 2002). Whereas the PA profession was developed out of the medical tradition, NPs approach patient care within the tradition of nursing (Cooper 2001). Both PAs and NPs are trained as clinicians who are licensed throughout the United States to practice medicine under the supervision of physicians (Cooper 2007; Hooker, Cawley, and Asprey 2010), although specific licensure varies by state. Studies estimate that PA/NPs can provide 80 percent or more of the services routinely provided by physicians, such as disease diagnosis, management, and treatment, providing a broad range of health care services traditionally performed by physicians, and at the same level of quality (AANP 2013; The Pew Health 1998 1). Furthermore, in most states, the supervising physician need not be present in order for the PA/NPs to practice. This relationship allows PAs and NPs to staff satellite offices in underserved areas where they can diagnose and treat patients with minimal supervision from a physician (Henry and Hooker 2007; Hooker and Cawley 1997; Mittman, Cawley, and Fenn 2002).

As the Affordable Care Act brings an expansion of health care availability to millions of people in the United States, the job growth for PA/NPs is rapidly expanding in physician-led teams to offset physician shortages. This increase in the collaborative model of health care impacts not only the types of providers patients see for care but also how that care is delivered.

Understanding the Culture of Community Health Centers

Irwin Press (1997) wrote about the quality movement in health care in the 1990s. He noted the importance of recognizing the role organizational culture has in shaping programs that lead to, or prevent, improvements in health care (Press 1997). Following Press, Winkelman (2009:107) notes, "Knowledge of organizational culture is crucial in addressing the bureaucratic processes necessary to develop and implement programs." Both authors call on anthropologists to research clinic culture and quality of care from a holistic, systems model approach that considers the clinic as a system of interrelated roles and responsibilities.

In my research, studying the role of PAs and NPs in CHCs in Texas, nine out of ten clinics utilized PA/NPs in the same capacity as physician—as providers with their own panel of patients. PA/NPs had their own patient schedule, and patients requested to see a specific provider, be it a physician, PA, or NP. Although PA/NPs worked with their own patients, when questions arose, they talked about the interactions among providers as a collaborative approach. The majority of medical staff interviewed concurred that this physician-led collaborative model of care provided the best continuity of care for patients. The tenth clinic differed and utilized PA/

NPs for triage, acute care, and same day appointments. This was an urban clinic in a medically underserved area that was used as a walk-in clinic for many uninsured residents. PA/NPs treated the walk-in patients and followed their care until an appointment could be made with one of the physicians on staff (sometimes taking as long as six months). At that time, the patient was assigned to a physician and could not request additional follow-up care with the PA/NP who cared for them prior to physician assignment. The PA/NPs interviewed at this clinic felt there was less continuity of care for patients. Patients were also less pleased with this restricted-access model than patients at the broad-based CHCs.

Relationships among Providers

Significantly, the difference in these two CHC models corresponds with the overall clinic culture, trust, and collegiality of health care teams. In the clinics where PA/NPs saw their own patient load, the entire medical staff described collaborative teamwork relationships regardless of urban/rural location or clinic size. As expected, the PA/NPs asked questions to the supervising physicians for complicated cases. However, despite the physicians' typical role of handling more complicated cases where patients have co-morbidity, they also sought out PA/NP experience and expertise when appropriate. One PA commented:

> [Questions vary] with day to day. I mean, some days I have a lot of patients that I ask a lot of questions about and some days I don't have any. I'm not hesitant at all to pull [the MD] aside to come look at this abdomen with me. Or I might say, "This is what's going on, this is what I want to do, what would you do?" Or, you know, "This is the kid we've been seeing for 'X,' he's now at 'Y,' where do we need to go from here?" You know, we've worked together for so long. And she does the same with me, you know. She says, "This kid has got this, you know, we've done this before, what would you do?" (PA, urban CHC)

In another urban clinic, a female PA had clinical experience in a state prison with a high incidence rate of skin ailments. In this case, the supervising physician would sometimes ask the PA for a consult with a patient who presented a skin condition. When asked about the working relationship of the PAs with other providers in the clinic, he noted:

> [She's] very friendly, very professional. She's supportive and feels very comfortable coming to us with a question. And vice versa, I'll go to her with questions. "What do you think about this?" I don't see a tiered level. As long as they work and they do the best they can and do an honest job, I'm pleased. Because I expect that of myself. I don't care what label they have. As long as they are qualified. (MD, urban CHC)

In one rural clinic, a male PA had thirty-five years of experience practicing in the same town compared to a supervising physician who had twenty years of primary care experience but only six months in the town. The PA treated

his own panel of patients, but when they developed complicated co-morbidities, their care was switched to the physician. Frequently, however, the physician would consult with the PA who had long-term knowledge of the patients themselves. He trusted the PA's connection with the patients and valued the added insight these relationships brought to achieving positive health outcomes.

In contrast, the one CHC that limited PA/NP patient load to triage and acute care described more contested relationships. In this large urban clinic, PA/NPs repeatedly requested to see their patients beyond acute care. They were unable to establish relationships with patients because patients are reassigned to physicians. Moreover, the physicians thought the PA/NPs should cover some of their patient load when triage was slow, but clinic policies would not permit it. There were tensions between providers, and unprompted discussions of teamwork and collaboration did not occur during the research. One MD noted, "Any questions [the PA] has, she comes to me. We expect that she won't do any procedure or do anything that the MDs wouldn't do. We don't want her to do anything that we can't fix." The relational dynamics and level of trust between the PA/NPs and MDs in this urban clinic stands in contrast to the other nine CHCs where medical staff often spoke of collaboration, collegiality, and mutual trust.

The Role of PAs and NPs in Community Health Centers

In a 2005 article, Deborah Boehm discusses the unintended roles of federally qualified health center (also known as community health centers) staff in New Mexico. These community-based centers provided comprehensive primary care, preventative care, and social support care to the medically uninsured and underinsured. She discusses the commitment on the medical and office staff who provide services that are often difficult to measure in terms of outcomes. They are patient advocates, and they are committed to making sure the patients are well cared for and have access to medical and social programs for which they are in need. Louise Lamphere (2005:15), in the same special issue of *Medical Anthropology Quarterly* on Managed Care, refers to these services as buffering activities of the unintended consequences of managed care that place a higher burden of "going the extra mile" on providers.

My research with CHCs in Texas echoes a commitment of medical staff towards total patient health and well-being. During interviews, the medical staff of CHCs discussed the comprehensiveness of the care and sometimes proffered that patients received better primary care at some CHCs than private practice. In eight of the ten CHCs, there are other specialty care services such as dentistry, women's health, mammograms, pediatricians, pharmacies, drug cessation programs, and cardiovascular programs. Some centers also provide social services such as legal aid and transportation. When asked about the level of health care available at the clinic, an urban medical assistant noted, "Here well, here we can say we're more like a family. Our patients are very

important to us and the fact that we are a government-funded organization and our quality of care is better than a private physician—a private care. I can say that because I worked in the private world too" (MA, urban CHC). A rural nurse stated, "Because we are federally funded, we are obligated to do more care than other clinics. We keep up to date vaccines, educate, refer to specialists, take more time to teach them, make sure they are up to date with preventative care—pap smears, breast exams, prostate screenings. We even reward showing up to appointments!" (LVN, rural CHC).

A significant pattern emerged when the medical staff was asked about the level of health care at the clinic and about the role of the PA/NPs. They noted that PA/NPs "bend over backwards" to provide patients with every needed eligible service. The best example comes from a rural clinic where two different nurses talked about an event between the PA and a patient. The female patient had a skin cancer spot on her face. She could not afford to get it removed by a specialist, and the PA had the skills to remove it at the clinic. One nurse noted, "Not only does [the PA] help them with treatment, she helps them moneywise—just to reassure them that 'hey, your health comes first.' She calms them down and reassures them that it will be okay—that their health is very important" (LVN, rural CHC). Another nurse commented, "This clinic does a lot! The best example is the cancer patient with the spot on her face. She was very concerned with money and would not have been able to get it removed if it had not been for this clinic and [the PA's] ability to remove it. The PA calms people down. Their health comes first. She paid for some of that procedure for the patient!" (LVN, rural CHC). PAs and NPs also work hard to identify specialists willing to accept patients and treat them pro bono. All of the PAs noted that their patients frequently tell them how thankful and grateful they are for their care, for being educated about their health condition, and for referrals to specialists. Overall, the medical and support staff of the CHCs appeared to care about patients and to take pride in serving them well (see also Henry and Hooker 2014).

Winkelman (2009:115) notes, "The social image of physicians is affected by their lack of connection with the life-worlds of their clients and their clients' lack of accessibility to their services. Changing physicians' images requires that they take activist roles in community health development and policy formation and serve as mediators and facilitators in public health and clinical contexts." I argue that in CHCs, PA/NPs are performing the roles that Winkelman suggests physicians should do to improve quality of care for patients.

PA/NPs in my study were noted to have "soft skills" that differ from physicians in CHCs. Notably, it was nurses and medical assistants who said that PA/NPs have a more holistic approach to patient care than physicians. When compared to physicians, they contend that PA/NPs: (1) look at the whole patient rather than the chief complaint; (2) talk more with patients; (3) do more patient education even with the absence of questions; (4) are more flexible; (5) are nicer to nurses, and (6) are more concerned with helping patients find social services. Although a time study was not conducted, the majority of medical staff said that PA/NPs took more time with their patients than physicians. One PA noted that she fills the entire 20 minutes allotted per patient in order to check over their whole body and/or educate patients on a particular issue. She states, "Because we are federally funded, I don't feel the pressure for high turnover and high patient counts that I imagine practitioners in private practice feel" (PA, rural CHC).

Relationships: Patients and Community

Winkelman (2009) and Walsh (1990) discuss changes in relationships between providers and patients that can improve both the quality of care for patients, who receive medical and social advocacy support from providers, and for providers who can experience a "helper's high" and sense of satisfaction from a more holistic scope of practice that addresses social causes of disease and lifestyle.

Relationships between PA/NPs and Patients

Nearly all medical staff in my research noted the most positive aspect of their work in CHCs is the working environment and close knit relationships they have built with patients, doctors, nurses, and other coworkers. They are gratified in being able to treat low-income patients, especially those who are underserved or suffer from health disparities, and they enjoy making a positive impact on their patients' lives and health outcomes. One rural PA commented on the most positive aspect of working in the clinic:

> You know, we see a lot of undocumented patients, and they are so grateful to be getting care at all…. They make it so rewarding to help. We get a lot of patients on Medicaid because the mom didn't know to look for Medicaid or help them, you know, find ways to pay for things. That is so rewarding and even those ones with insurance…just knowing that you are appreciated because you spent the time listening to them. The nurses are also really great. It really is kind of like a small knit family (PA, rural CHC).

PA/NPs report that the patient population is what influenced and inspired them to practice in a community health center. They enjoy the openness and accessibility of patient relationships as well as the range of patients they treat. To be balanced, PA/NPs also note that patients are their number one cause of frustration in their work as well. Reasons for this frustration include high volume of patients, patients not following the provider's recommendation, and lack of health literacy.

The patient's viewpoint is vital in understanding the relationships between providers and patients. "Quality of care is an experience based in patients' personal, social, and cultural expectations and has become a legitimate criterion in the health industry for assessing patient satisfaction and determining how to improve health care" (Winkelman 2009:16). Patient satisfaction with PA/NPs is particularly well-researched in health

service fields, and because these providers ensure that patients receive the personal attention they need, they significantly contribute to patient satisfaction (Drozda 1992; Henry and Hooker 2007; Henry and Hooker 2014; Hershey and Grant 2002; Hooker 1993; Hooker and Berlin 2002; Hooker and Cipher 2005; Hooker, Cipher and Sekscenski 2005; Hooker and Freeborn 1991; Hooker and McCaig 1996, 2001; Hooker, Potts, and Ray 1997; Mainous, Bertolino, and Harrell 1992; Nelson, Jacobs, and Johnson 1974; Oliver et al. 1986; Ruby et al. 1998). Patients within the CHC research indicate that PAs were highly effective, efficient, knowledgeable, and seem to genuinely care about the patients. There were many patients who said they "loved" their provider, and treatment and care were considered helpful and appropriate. When asked why they chose to see a PA, patients expressed a sense of loyalty to the provider they have seen multiple times, though many did not distinguish between an MD, PA, and NP. Many were also referred to the PA by a friend or other provider. Interestingly, patients were less satisfied with care received in the clinic where PA/NPs were used in triage and acute care. Patients did not feel connected to their providers and make comments such as, "I didn't choose him; they assigned him to me." "Because I couldn't meet the doctor that I have." "Because the doctor was unavailable." Patient satisfaction is related to trust that develops with provider-patient relationships and continuity of care.

Relationships between PAs and the Community

Baldwin, Sisk, Watts, McCubbin, Brockschmidt, and Marion (1998) note a difference between patient satisfaction and community acceptance. "Community acceptance implies not only satisfaction with the care received but also a willingness to initially seek care from a PA or NP" (Baldwin et al. 1998:389). In a 2007 study on retention of physician assistants in rural CHCs, I researched the relationships of PAs and their surrounding communities (Henry and Hooker 2007). PAs in this study worked in rural health clinics that were more than 25 miles from the nearest medical facility with another provider, were practicing autonomously with less than eight hours per week with their supervising physician, and were employed at their current rural clinic for at least two years. I interviewed PAs, community leaders, town residents who were patients of the clinic, and town residents who were not patients of the clinic. There was a strong feeling that PAs who were actively involved in the community were committed to the town and its well-being. Town residents desired that PAs be involved with the community because they felt participation builds trust and familiarity. They wanted to see the PA and the clinic staff sponsoring information fairs, going to the senior center for blood pressure screening, assisting with immunizations, and being on-site during sporting events. Notably, the PAs who lived within the communities in which they practiced had a closer and more trusting overall relationship with the community and clinic patients than PAs

who lived in another town and commuted to the rural clinic. Local PAs appeared committed to the well-being of the town not only in terms of health care but also on a social and civic level. When asked how important it is to be active in the local community, one rural PA noted:

> It's extremely important. I'm the city's health officer because there are two other doctors in town—one is the dentist and one is the veterinarian. I help out at the local high school doing physical and working sidelines at the football games. I also work with the SWAT team, serve on the Red Cross and juvenile boards, and teach sports medicine at the junior college. You need to give back to the place where you are (PA, rural CHC).

When asked if active participation in the local community was necessary to get patients to accept him as the only practitioner in town, he replied, "No, but it helps. I go to the high school football games. I help the kids out, and people in the stands know who I am. There is no question that I am there every Friday night to help them out. Do all of them come and see me? No, but they know that I am there helping, so it puts a better light on the clinic" (PA, rural CHC). Another PA noted, "You're an outsider in a small town like this until you have two generations—your kids and your grandkids. Then people will treat you like you're from here. So community involvement is real important. I realize that more and more all the time that I've got to be active and things like that." The PAs who live in town and put down roots seemed less likely to leave their job than PAs who lived and worked in different towns. Their goals and future plans included the local community. This means greater continuity of care for those who use the CHC and possibly improved health outcomes as a result.

Critical medical anthropology points to the power imbalances between physician and patients within the medical encounters and seeks to understand how these power relationships are shaped by poverty, inequality, and other macro-level forces. While I agree that some town residents may not have health care options beyond the local, rural clinic and may resort to the only option available, many town residents have choices—and with choice comes power. Those with economic or social capital resources have the power to reject the local, rural clinic and seek care from other providers. The issue of retention is significant in this discussion. Many town residents are dissatisfied with rapid turnover of medical providers in their small towns. They choose to drive long distances to see providers with whom they have established long-term trusting relationships. Relationships and trust become important elements in the delivery of health care, the kind of care provided, and health care policy.

Discussion: Beyond Critical Medical Anthropology

In a 2005 article in *Anthropology and Medicine*, Hemmings (2005) observes that critical medical anthropology has made tremendous progress in articulating the problems

of biomedicine but has done little to offer solutions. In his exploration of the ways medical anthropology needs to change, he suggests the need to understand physicians better and to conduct more physician-patient interaction studies. Following Maretzki (1985) and Stein (1987), he notes that medical anthropology has typically taken the perspective of the patients, identified with the patients, and failed to provide a holistic analysis of the medical encounter. The theoretical lens of critical medical anthropology may prevent analysis of physicians as "humanitarians, open to change and hard working for their patients" (Hemmings 2005:98). Hemmings and others (Stein 1980; Wallace 2011) call for more balanced and holistic ethnographic explorations of clinics and clinical interactions within critical theory.

Holmes, Jenks, and Stonington (2011:108) review the literature on the process of learning detachment and the medical gaze, or outward gaze, (Davenport 2000; DelVecchio Good 1995; DelVecchio Good and Good 1989; Foucault 1984, 1994; Good and DelVecchio Good 1993) through which "biomedical reductionism refashions the patient as a body, an object to be diagnosed, and refashions the boundaries of the trainee in relation to that object…." However, I find more useful their discussion of Foucault's (1988) volume *The Care of the Self*, where they describe the process of self-formation and relate this to medical providers. Medical trainees are not simply shaped and molded by the medical model but rather "are also active subjects who make choices, resist subjugation, accommodate power differentials, and use techniques to actively craft themselves internally throughout the process of becoming a new kind of professional" (Holmes, Jenks, and Stonington 2011:109). Foucault (1988:43) refers to this as the "cultivation of the self" and posits that humans have dual outward and inward gazes.

My research demonstrates the extended role of PA/NPs in medically underserved community health centers. It highlights the relationships they forge with other providers, patients, and communities to emphasize the trust and commitment of PA/NPs to a holistic approach to patient care that includes health care and social well-being. These providers frequently "go the extra mile" to provide services that are difficult to measure in terms of outcomes. As PAs and NPs begin to fill the gaps of physician shortages, particularly in primary health care, it is important to understand who they are, what role they perform, and how they approach patient care within a biomedical collaborative care model.

Conclusion

As health care policy continues to evolve, the clinical scope of practice for PAs, NPs and other "intermediate-level" practitioners will have a significant effect on clinics. For example, lawmakers, physicians, PAs, and NPs reached an agreement in Texas in 2013 to expand the scope of practice for PAs and NPs in order to extend coverage and improve patient outcomes. Specifically, this new law will ease physician supervision requirements for PAs and NPs,

increase from four to seven the number of PAs or NPs to whom a doctor may delegate authority, and allow physicians to delegate Schedule II controlled-substance prescribing authority in hospital and hospice settings. These expansions will relieve some of the legislative limitations of PA and NP practice. Medical anthropologists have much to contribute to these policy discussions and related research.

In 2009, the Society for Medical Anthropology President Carolyn Sargent (2009) called on medical anthropologists to "Take a Stand" on national health care policy and health care reform in order to effectively inform policymakers at local, state, and national levels. In 2010, the new Health Care Reform Taskforce was formed "to explore systematic ways for anthropologists who are in positions to track these effects to communicate their findings through channels that can impact policy and practice" (Craddock Lee 2010:27). This call for more research on the national health care crisis and more influential engagement of anthropologists on policy echoed previous calls for additional research. In 2000, Merrill Singer called for further ethnographic research and analysis on poverty, health, and health care in the United States. In 2002, Rylko-Bauer and Farmer noted a dearth of anthropological voices in the analysis of national health care. In 2006, Horton and Lamphere called for more ethnographic analysis to inform current policy debates, which came on the heels of Lamphere and Nelson's (2005) special issue in *Medical Anthropology Quarterly* on how providers and staff responded to changes in managed care. This ethnographic research highlights the role of PAs and NPs in providing collaborative care in federally-funded CHCs, which are at the center of an evolving health care system working to bring accessible and high-value primary health care to the medically underserved. With the rapid growth expected in the workforce of PAs and NPs there is much research to continue in this area, particularly within expanding community health centers and the medically underserved.

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