Full Practice Authority and Responsibility (FPAR)

Frequently Asked Questions

What exactly is the Task Force proposing?
The Task Force believes AAPA should adopt policy to do four things:
- Emphasize our profession’s continued commitment to team-based practice.
- Support the elimination of provisions in laws and regulations that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician in order to practice.
- Advocate for the establishment of autonomous state boards, with a voting membership comprised of a majority PAs, to license, regulate, and discipline PAs.
- Ensure that PAs are eligible to be reimbursed directly by public and private insurance.

FPAR is a straightforward concept: PAs should be responsible for what they do each day; PAs should regulate their own profession; and services provided by PAs should be covered by public and private insurance. All of this can and should occur within the construct of team practice.

Why does the task force think this is necessary?
The healthcare system is transforming, and the task force believes that these changes are required to protect the profession’s future. Years ago, many solo physicians hired PAs. It was a nice relationship, especially for a new profession. It will not work in the future. Going forward, most physicians will be employees, not employers. Physicians will not want to work with someone who will increase their liability but not their income. They will look to providers who can be colleagues and who carry no risk to their license.

Additionally, hospital systems and other PA employers are beginning to favor hiring NPs who do not have to have a registered physician supervisor over PAs who are required to do so. Not only does full practice authority reduce the amount of paperwork involved in hiring NPs, but it also gives employers more flexibility in redeploying staff, as may be required to meet patient needs.

We are seeing this now as physicians and hospital systems across America are beginning to turn increasingly to NPs in states where they have full practice authority. And recently, the nation’s largest employer of PAs – the Veterans Administration – gave APRNs full practice authority. The fact is, if we wait much longer, we will be too late.

Does this mean the profession is pursuing independent practice?
While the FPAR proposal suggests removing a legal tie to a specific physician or group of physicians, it does not propose that PAs practice alone. In fact, it commits PAs to team practice with physicians and others.

The task force does not view or promote FPAR as independent practice and agreed unanimously that reinforcing team practice should be the first pillar of the proposal. The PA profession is committed to
team practice. We think it’s good for PAs, other members of medical teams, and most importantly for patients. People who choose to become PAs are team players and PA education reinforces team practice. The task force does not see a need to change any of that. It has a 50 year track record of success.

How would FPAR change my practice?
The task force doesn’t anticipate much will change in day to day practice. If FPAR is enacted into policy and subsequently enacted as federal and state law, PAs who work in licensed facilities will still go through credentialing and privileging, and will function as team members on services that include physicians and others. PAs who work in outpatient medicine will consult and refer just as they do now.

What would change is a PA’s ability to change jobs or work with new physicians without getting signatures or filing paperwork without risking being in violation if signatures are delayed or missed.

FPAR would also mean that you would be licensed by a board with a majority of PAs, who understand your education, training and practice. Right now, only five states (Arizona, Iowa, Massachusetts, Rhode Island and Utah) have autonomous PA boards, and only one, the Iowa board, has a majority of PAs.

How did the Task Force get started?
Last May, the House of Delegates considered a resolution on full practice authority that was submitted by the Association of Family Practice PAs, but decided at that time that it deserved additional thought. In addition, the Board included an examination of the issue in its latest Strategic Plan. The confluence of these two actions led to the creation of the Joint Task Force on the Future of PA Practice Authority. The task force, which is comprised entirely of PAs, devised the current Full Practice Authority and Responsibility proposal.

How would a PA’s scope of practice be determined under FPAR?
AAPA’s new Guidelines for State Regulation of PAs, adopted by the 2016 House of Delegates define PA scope of practice very broadly, and no longer limits it to a physician’s scope of practice or physician delegation. That is already AAPA policy. An individual PA should include in their scope those aspects of care that are within their education, experience and competence. Like all health professionals, that changes over time.

Who would be responsible for care provided by PAs under FPAR?
Just as now, PAs are responsible for care they provide. Requiring a physician to also be responsible for PA-provided care is no longer part of AAPA policy. The new Guidelines for State Regulation of PAs call on PAs to be solely responsible for their actions, unless they are implementing a direction from a physician. This brief explains why PAs should be responsible for PA-provided care and this video shows the changes in the new Model State Legislation and the Guidelines for State Regulation of PAs.

While removing physician-responsibility is now AAPA policy, it has not been implemented in many state laws or regulations. FPAR takes this concept one step further by clarifying that a PA does not have to have a supervising/collaborating physician who is willing to take responsibility for the autonomous clinical decisions made by a PA. FPAR is a way to implement the concept that physicians should not be responsible for PA-provided care.

What evidence do you have that PAs can practice safely and effectively without having to have or report a specific supervising/collaborating physician?
Studies show that the care provided by PAs (who make autonomous clinical decisions daily) and NPs (who are already permitted to practice without designating a supervising physician in many states) is equivalent in quality to care provided by physicians. We've included a bibliography of studies on quality, cost effectiveness and access to care as a link on this page. We think that under FPAR, PAs and physicians will work very similarly to current practice patterns. But neither will be burdened by administrative hassles that have no value to improving patient care.

Does the task force foresee any changes to the PANCE/PANRE if FPAR were to be implemented? Does the task force foresee any additional examinations that PAs would have to take?

FPAR would not, in and of itself, expand a PA’s scope of practice. PAs will continue to have to practice within the bounds of their education, training, and competence. PAs who work in licensed facilities will still go through credentialing and privileging, and PAs who work in outpatient medicine will work within the bounds set by their employer and continue to consult and refer, just as they do now. While we cannot speak for what NCCPA (the organization that determines PANCE/PANRE requirements and content) may do in the future, we see no reason that FPAR would impact those exams.

Won’t implementation of full practice authority and responsibility expose PAs to more medical malpractice claims?

PAs are already liable for their medical decisions. There is no reason to believe that implementation of full practice authority and responsibility will create an incentive for PAs to practice outside of their demonstrated scope of competency. That’s prohibited and unethical now, and will continue to be. At the same time, this change might make it more likely that physicians will be willing to work with PAs, because they will no longer be liable for medical decisions made by PAs in which they played no role. The task force thinks that’s a good thing.

How much will this affect the cost of PA malpractice insurance?

Since PAs are currently liable for the medical decisions they make, we do not believe there will be cause for PA malpractice insurance rates to increase. Since a supervising physician will not be automatically liable for the care provided by a PA, it’s possible that there could be some shift in the malpractice insurance market. We are in contact with malpractice insurance companies to get a more informed response to this question.

We have built some good relationships with physician groups, and this may cause them concern. Wouldn’t it be better to just continue to make the slow and steady progress that we have been?

Times have changed. Younger physicians and physicians who work as employees (rather than practice owners) – both a growing percentage of the physician workforce – do not want to “supervise” and take responsibility for the decisions of PA co-workers and colleagues. We will need to work to ensure that physicians understand our vision and intent. We are not abandoning our commitment to working in teams with physicians and other healthcare providers.

We believe that FPAR has significant benefits for physicians. Administrative headaches and paperwork will decline because PAs would no longer be tied by law to a supervising or collaborating physician. Physicians won’t have to undertake useless tasks like filing meaningless paperwork. The change would reinforce the notion, long backed by AAPA, that PAs should be liable for their own medical decisions. We think these changes are better for both physicians and PAs.

What are the chances for the implementation of full practice authority and responsibility?
That depends on how hard PAs work to pass new laws and what kinds of alliances we are able to build. But our first job is to achieve as wide a consensus as possible within the PA profession. That is why we are asking PAs like you to give us your feedback and suggestions for improvement.

We believe Full Practice Authority and Responsibility is absolutely within our grasp. But we’re going to have to work hard to adopt thoughtful policy and to implement it.

**Can the profession embrace FPAR without changing its title?**
The task force recognized that changing the name of the profession is an important topic that could gain added urgency if Full Practice Authority and Responsibility becomes AAPA policy. However, while there is considerable dissatisfaction with the title of “Physician Assistant”, we recognized that no clear consensus on an alternate title has emerged. The task force believes that moving to FPAR is critical for the profession’s viability and should not be delayed by the issue of changing the profession’s title. Additionally, we agreed that tackling the name change topic is outside the scope of our charges. We believe that another group should be convened to undertake the research and PA community engagement on the topic of name change, and invite your feedback on that suggestion. In the interim, the Task Force intends to use the acronym “PA”, consistent with the current AAPA convention.

**What are the next steps?**
It is clear that changing state and federal laws and regulations, as well as the policies and practices of employers and insurance companies, will be challenging and take time. The first step, however, is to reach agreement, as a profession, about the future that we will work to achieve.

Just as PAs do in their everyday practice, the Joint Task Force on the Future of PA Practice Authority recognizes the limits of our collective and individual experiences. For that reason, we seek the feedback and input of our fellow PAs and the full range of AAPA constituent organizations. We hope that you will engage in dialogue with us and with each other through Huddle or through social media. We seek your views through email or letter. And we intend to send out a survey to individual PAs. And we expect to discuss these important issues with you at the Leadership and Advocacy Summit (LAS) in early March.

Once we hear from you, we will come together again to reconsider and, if necessary, revise our position. It is our expectation and intent to offer a resolution to the AAPA Board of Directors and the AAPA House of Delegates for their consideration in May 2017.