“I must not have been one of the polled PA’s but HAVE experienced loss of job opportunity to NP due to supervisory issue. I think there are some specialties where a PA could not practice independently, for example as with my background of neurosurgery. But I found it very frustrating to have assisted in intracerebral vessel dissection & not be able to inject Botox or operate a laser for anything cosmetic other than hair removal...& in the state of Ohio such an "easy" job is going to NP’s.” PA (Ohio)

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“As a PA in clinical practice for 23 years and in dermatology for 20 years, I fully support the position statement set by the SDPA regarding FPAR.

I also support a name change for this task force in the hope of preventing further backlash that has been occurring simply in response to the name of the task force itself. For some supervising physicians and PAs the name alone starts the tone off in a negative light and unfortunately those individuals tend to then have preconceived notions before fully understanding the beliefs that the task force is proposing for AAPA policy. Please give your full consideration to a name change that reflects an overall positivity to our constituents, supervising physicians and the public.” PA (Nebraska)

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“I wanted to email to express some concerns I have about Full Practice Authority for PAs. My opinions and concerns are mine alone and are not a reflection of the PA program in which I teach.

In our rural community in Virginia we are already making slow headway with gaining physician trust of what PAs are capable of doing. Some physicians love and advocate for the autonomy of their PAs while others hamper our progress in even being able to write notes in the hospital on our own. The physicians that advocate for PAs do so over the NPs as they feel that we are capable but not trying to be independent, like the NPs. With our profession asserting its independence, I feel that these relationships would be damaged. While I feel that PAs with experience and continuing education may be completely capable of practicing independently, the students coming out of school are prepared but not yet capable.

In Virginia, with our practice agreements being kept in house, I feel that a new graduate is more supervised and then as time goes on and trust is built with the physician then PAs are given
more autonomy and responsibility until they basically are independent providers with a supervising physician of record only. Medical students coming out of residency are not treated this way. They are expected to practice with full responsibility from the time they are hired, but they have also had more experience and more breadth and depth in their didactic years than our PA students. If we try to implement full practice authority, I feel that more offices and hospitals are going to require PA residency programs before hiring an independent provider to allow for the gap in experience between a new graduate PA and resident. Or physicians may give our PA graduates lower pay until they have more experience before paying them like an independent provider.

While I like the concept of billing for reimbursement on our own, being our own provider would indeed cause malpractice premiums to increase due to the lack of supervision in the eyes of the malpractice companies. PAs already accept responsibility for what we do daily as well as accept the liability for what we do as well. I try to teach our PA students about billing and coding and how to get the most out of reimbursement. The current reimbursement is really not bad for a physician to be able to double the patients he sees while paying a PA almost half what he would another MD to do the same thing.

Full Practice Authority would completely change the profession. It would change how we are viewed by the community and it would change how we have to train our students. While we value team practice now, I believe that this will almost eliminate the team based approach working with physicians and other NPs and PAs in the long term. I currently practice very autonomously and with great responsibility but that is because I have the experience and have built that trust with my supervising physician. There is no way that I could have practiced this way directly out of school even though I feel that my PA training was extraordinary; however, it only took 6 months for my supervising physician to see my potential and ability and increase my autonomy and responsibilities. I enjoy having the physician I work with look over a percentage of my work and give me suggestions for improving my practice and abilities, things that he may have learned in medical school. I feel that this benefits me and the physicians and especially the patients for which we care. The relationship between the supervising physician and the PA does not have to be one of oversight but of team based collaboration and we have created an environment in Virginia where this can be possible. I believe that implementing full practice authority would damage this relationship and make it harder for the trust between physician and PA to develop and now they would be in competition with each other.” PA (Virginia)

“I think that one of our greatest strengths as PAs is our unique relationship with supervising physicians. Not only does it allow us to enter the work force after only a few years of schooling, it allows us to continue to have a continued mentor to learn from as we become more experienced as health professionals. I personally disagree with the pursuit of FPAR and think it would be a detriment to the profession. I do not think our training is extensive enough to support that kind of autonomy. Not only is physician partnership the foundation of our
profession, it is even a part of our name. Thus, I strongly believe the pursuit of FPAR would not be beneficial for the PA profession.” PA (South Carolina)

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“Why, after more than 50 years as the good right hand of the physician, should the Physician Assistant profession be thinking about full practice authority? Part of the reason has to do with the growth of the profession from a certification many years ago to a masters level program standard today (with a trend towards PhD level training). The rest of the reasons have to do with practical realities of our current health care environment and the current political trends.

Without argument Physician Assistants are now better trained and educated than ever before. Despite some fringe arguments this does not bring us to the level of physician training. It does, however, bring us to a level where close supervision by a physician, and all the rules and regulations that accompany that, have become superfluous and now represent barriers to care while increasing the cost to provide services. “Supervising” a Physician Assistant typically costs more than $12,000 annually.

The other part of the discussion, and possibly the more compelling one, has to do with keeping the profession on par with our counterparts the nurse practitioners. NPs currently have full practice authority in 22 states with legislation pending in many more. There are many many arguments about who is better trained and more skilled and that has no place in this discussion. The simple practical truth is if we, the Physician Assistants, don’t maintain regulatory parity with the NPs it will have a deleterious effect on the profession as a whole.

In Texas NPs have been unsuccessful in many attempts to achieve full practice authority. Stopping them will not last much longer and there is currently draft language supported by some Texas legislators which removes all language regarding supervision from our shared practice act for the NPs only while leaving them in place for PAs. This full-on change probably will not succeed but some incremental changes are highly likely. Physician influence in the Texas legislature has been on the decline for years as many have figured their positions are often based on power and control and less on what is best for patients. Their ability to stave off the NPs is at an all time low as evidenced by the many states that give NPs full practice authority. It will be like the metaphorical snowball rolling down hill and the PAs will be left behind because our state professional association actively opposes full practice authority for PAs. This is a short sighted position that will blow up in all our faces. Texas is ranked 49th or 50th nationally in delivery of health care and legislators are waking up to the idea that physicians can’t solve the problem.

If NPs achieve full practice authority they will become the overall preferred “mid level”. It will become less expensive to hire and utilize them and, because they have full practice authority, then can then hire and supervise Physician Assistants. Physician Assistant salaries will decline. Job opportunities will decline. Physicians are becoming salaried employees more and more and
have less and less influence over hiring and salaries. Those decisions are made by administrators and will be driven by finances and convenience.

There is a belief among many that, by remaining the faithful servant of organized medicine, we will share their power and be their preferred mid level. That will be true to a point but, as stated above, has become less and less relevant to the health of the profession and will continue to become less meaningful. When we no longer serve the physicians agenda they will cut us loose. At that point we will be politically adrift and far far behind the NPs. Is that really what we want to do just to avoid upsetting physician organizations? The physicians have opposed NP practice authority with all their might and yet NPs enjoy full practice authority in 22 states and are the preferred mid-level by most estimations.

This is a conversation that needs to be had and sooner rather than later.” PA (Texas)

“...I agree with AAPA’s stance on full practice authority. I work for the va and before that in a remote WA state Native American clinic. In both settings NP’s have outdistanced PA’s...in rural settings NP’s were preferred as they did not require oversight, in the VA system NP’s are favored and paid better for various reasons. VA will even advertise for the same position but offer higher salary to NP’s than to PA’s. And now the VA has decided to formally grant all NP’s full practice authority.

The writing is on the wall, we either jump ahead into a future as independent practitioners with full practice authority or disappear as a profession.” PA (Texas)

“There have been fundamental errors made with this profession dating back years. When I graduated in 1978 I already had a BS and was asking why I now was getting an associates degree instead of a Masters. We all know how that went. But no, another error made when previous grads were not grandfathered in to receive Masters . Then we let years go by and the AAPA, which was supposed to b protecting our interests never started towards independent practice until at least 20 yrs after the less well-trained NPs had already had this distinction. For instance, with 39 yrs of experience I thought about retirement and we moved to be closer to daughter who lives in Canada. I am bored and wish to return to work. So far new grad NPs seem to have the lock on the job market even in these rural areas when experience is a huge asset since we all know in reality we practice independently. For shame AAPA!” PA (Minnesota)

“As a non-hospital healthcare administrator for 14 years and a PA for 20, I support FPAR. Healthcare marketplace and overall paradigm changes make the time right to make this logical move. PAs provide excellent care and should prepare themselves to practice safely at the top of our license. Our challenges
will be that the regulators, payers, malpractice insurers, and state practice acts must also change in relatively short order to make this work. Additionally, it seems anecdotally that the NPs have accomplished independent practice insidiously; most physicians don't even realize that NPs have always espoused independence while we have historically advocated team practice. All the while, physicians continue to lump us with the NPs while we do not enjoy the legislate and regulatory benefits.

This will be a long and arduous legislative battle against physicians. They have much more financial capacity for legislative advocacy and will be asked first and often if FPAR is a good idea. The nurses, by virtue of their strong lobby, will also have their opinions heard. Our training, goals, and motives will be called into question. The worst examples of our colleagues' behaviors will be used to classify us all. Unfortunately, we PAs have been notoriously complacent in supporting advocacy efforts. I hope for the sake of our profession's future, we are prepared to see the task through if we undertake it.” PA (North Carolina)

“I have experienced the pinch as well. I'm entering my 20th year as a PA and NPs with less than 3 years experience are opening clinics, being allowed to work 24 hour shifts in critical care access and ER facilities. I was refused hire, due to the physician supervision clause in 3 cases. In all cases, I work along side these NPs in other settings and have assisted in their training and mentoring. The NPs have couldn't believe that someone with my experience, couldn't be hired, due to PA laws.

NPs are becoming the main Primary care providers and filling the gap of shortages of Physicians. I work in a traditional ER setting in Texas and Louisiana, and the majority of patients use a NP as their PCP and are becoming more and more accepted throughout the medical community.

We have to change the laws with the needs. Our talents and training is going unused and we are quickly losing ground in this arena.

Another NP has been trying to recruit me to North Dakota and his administration has said he'd love to hire me, but can't due to signatures and supervision requirements.

100 percent of the time physicians are noticing the difference in our training and competence, and prefer us due to competence, let's do away with these restrictions and be the leaders we were meant to be.” PA (Louisiana)

“It takes courage to lead and make a decision concerning our practice but fifty years have demonstrated that we are committed, qualified and educated to make this move as has our NP counterparts. It will require much work from the professional ranks and the support of the old guard to be open minded and pass the baton to the new generation of PAs. To the pioneers who worked so hard to make us recognized I challenge you to support remembering that"An
open mind is like a parachute --- it only works when it is open." Anthony J. D'Angelo, founder, Collegiate Empowerment Fir all practicing PAs, now you have a reason to join your national organization.” PA (New York)

“As a practicing PA for over 14 years, I whole heartedly support FPAR. It’s way overdue. Our profession must evolve with the times in order to survive and contribute.” PA (Texas)

“Yes. I am absolutely in favor of FPAR. It is way past due for PAs.” PA (Texas)

“I have been a board certified P.A. for 12 years. As medicine and the insurance world evolves so should the profession of physician assistants. In my experience over the past 12 years more and more responsibility has been demanded of me to keep up with patient load, paperwork, etc. and I am now expected to do things that were once only done by doctors. I see more patients now than I used to and get reimbursed less by insurance companies. It is important that our profession changes with times, and the handcuffs be taken off, so we can care for patients effectively and also be adequately compensated for what we do. I 100% support FPAR for the bullet points listed below.

- Emphasize the PA 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”

PA (Texas)

“I could not disagree more with this proposal. I fail to see any benefits at all to this. Hard for me to believe that this is what my profession has morphed in to. I know the new generation of PA’s think they are smart enough to practice without any supervision but they are sadly mistaken. You are not a Doctor. If you want to play Doctor then go to medical school. My opinion.” PA (Maryland)
“My concern is that if the PA profession does not fight for as much autonomy as APRNs we will find a substantial decrease in the demand for PAs in the Primary care setting. In my recent job search I find more of a need for Physician Assistants in Surgery, Orthopedics and Emergency medicine/ Urgent care. Most Primary Care settings favor hiring APRNs over PAs due to their ability to practice independently and I have personally witnessed this during my job search for Primary Care jobs.

Autonomy is not a new concept to organized medicine in regards to other advanced providers, but historically has not been PA driven or an applied idea. The Health Care System is rapidly evolving and yet the PA profession is lagging behind. With the enactment of the Affordable Care Act more and more people are insured and are seeking medical care. According to HRSA, If the system of delivering primary care in 2020 were to remain fundamentally the same as today there will be a projected shortage of over 33,000 Primary Care Physicians. The supply of Primary Care PAs is projected to increase by 58 percent in the year 2020. Assuming that NPs and PAs provide the same proportion of services they did in 2010 the demand for the increasing number of PAs will only be 17%. If on the other hand NPs and PAs are used to provide a greater proportion of primary care services, their projected demand will be higher. Many PAs already practice medicine autonomously with very limited supervision from the Physician. The time has come to incorporate the concept of optional independence for seasoned Physician Assistants in the Primary Care sector. As the increase in patients requiring primary care exceeds the number of practicing Physicians in Family Practice able to care for them, PAs will be and are on the front lines. Physician Assistants should be able to practice at the top of their education and skill set. APRNs are having laws passed to gain independent practice from MDs after three years of supervised practice and have been granted that right in 21 states. APRNs are now able to practice independently in CT in order to fill gaps of primary care provider shortages across the United States. The postgraduate curriculum of the NP program trains NPs with less than half the clinical hours needed to graduate from an accredited Physician Assistant program. Nurse practitioners need to complete about 700 clinical hours during their post baccalaureate training and 1000 clinical hours from doctoral programs. That does not compare to the 2000 hours completed by Physician Assistants and in no way compares to the 12000 hours completed by Physicians during their Medical school and residency training. Furthermore NPs’ recertification is every five years and consists of logging CME and at least 1000 clinical practice hours. They are not required to take an in depth Recertification exam like PAs and MDs. If state statutes have changed to allow for independent practice of NPs or to loosen restrictions and supervision requirements in order to meet the healthcare needs, it is only natural that PAs follow the same path. Several major studies measuring outcomes of NP/ PAs have put them on Par with Physicians. In fact the Institute of Medicine in 2010 called for PAs/ NPs to be licensed to the full extent of their education and training. The law should accurately reflect what PAs already do, particularly when some of the language that governs PA practice is no longer functional in how care is delivered in modern day medicine. The statute should do away with face to face chart reviews for seasoned Physician Assistants and co signatures for home health care orders which overwhelm the already busy Physicians who practice in time constrained settings and is often done perfunctorily. The intent of full autonomy is not to sever or separate the PA/ physician relationship. To the contrary the intent is to legally reflect how we already deliver care with the
variety of professionals we are trained to work alongside on the medical team. I work at an outpatient Primary Care FQHC in Connecticut and have over a decade of practice experience. In my day to day practice there are several restrictions in place that make me feel as if I’m not practicing to the full scope of my education and training. The collaborative agreement at my facility states there should be weekly face to face meetings for chart reviews with documentation. This no longer applies APRNs since they are able to practice independently. This is not feasible and takes away from time with the patients. In reality what is going on in my setting is a collaborative relationship where ideas are bounced off of each other all day long. With NPs having independent practice granted in so many states I am concerned it might imply to MDs that PAs are not as qualified or competent, and whom might see PAs as a burden due to increasing paperwork. Also the exclusion of PAs from certain legislature due to not being recognized for their role in the Healthcare field has impacted their practice. An example was the implementation of EHR incentive programs which excluded PAs from being eligible; It resulted in a freeze on hiring PAs at the clinic I am employed at. PAs are trained in the medical model and taught to generate a thorough differential for a wide variety of clinical problems. It is disturbing to see that many MDs are more willing to hire NPs over PAs due to looser practice restrictions. MDs having to co-sign orders such as HHA orders, Medical supply orders, Disability forms puts a damper on their productivity. Is the PA profession moving toward a subspecialty profession and moving away from the very premise the profession was built on, that of Primary Care. PAs should be allowed to practice medicine to the full scope of their skill set and education to accurately reflect their contribution to medicine and become respected partners in the healthcare field. In applying Darwin’s theory to the evolution of medicine, if we don’t evolve with this changing Healthcare system I fear the PA profession especially as it relates to Primary/Family medicine may become extinct.” PA (Connecticut)

“I felt the need to write in support of full practice authority for physician assistants. I have a number of incidents in which this would be helpful which I will outline below.

1. I am a physician assistant who has practice in primary care for the past 9 years. I provide psychiatric care on a limited basis (10 hours per month) to students at a local college. The college does not have the funding to provide a supervising physician and therefore, tend to hire nurse practitioners. I was able to find a physician to agree to supervise me for this position, however, it is limiting, and my job there is completely dependent on this physician's willingness to supervise me. Additionally, I must provide my own malpractice coverage for this position, which means, my supervising physician must also provide their own malpractice and moonlighting coverage, in addition to my alternate supervising physician. I understand the need for collaboration and collegiality, but the supervision in this particular instance serves as a barrier to providing psychiatric care to those who severely need it.

2. I have multiple conversations with those in Idaho who prefer to hire nurse practitioners over PAs simply due to the need for supervision. Idaho is 99% a MUA, HPSA and many of our physicians are maxed out at the number of PAs they may supervise. They also may be hesitant
to take on a PA due to the risk of law suit in the event the PA is sued, which prevents some employers from hiring physician assistants.

In order to provide care to those who are medically underserved, and to ensure that the PA profession is successful, I strongly support the move to full practice authority.” PA (Idaho)

“I have been watching the discussion and debates about this issue for a while now and feel that I have to let my voice be heard.

I have been a PA for 25 years and have never had any regrets about making this my career choice. I tell everyone I meet that becoming a PA was one of the best things that I have ever done. Part of that is because of the supervisory relationship with an MD. We have forever been telling the doctors that we DO NOT want independent practice and that this is one of the things that makes us different from Nurse Practitioners. And now that their fears are coming true, what are we going to say to them? "Sorry, we were just kidding."? "Thanks for helping us to become this established, respected profession within the field of medicine, but now we want to be in competition with you."? It makes us sound so disingenuous and ungrateful for what they have done for us for the past 50 years!

I personally feel that if a PA wants to practice without a formal supervisory relationship, then he or she should consider going to medical school or even going to nursing school and become a Nurse Practitioner. Stop trying to change the PA profession! Stop trying to change the name! If you regret that you became a PA, I’m sorry. But don’t try to change the profession that I love and have absolutely no regrets about!

If the AAPA BOD and HOD want to continue to pursue this notion of autonomy, I will be forced to terminate my relationship and support of the AAPA. Thank you for considering one PAs opinion.” PA (Massachusetts)

“As a PA for 27 years, I think it’s a bit late to try to claw back the ground that we yielded when the nursing profession pursued independent practice in a big way approximately 20 years ago. At the time, AAPA chose the ‘lap dog’ position of forever hitching our practice to the continued good will and benevolence of physicians. As long as we didn’t make waves or appear to reach above our professional station in life, they’d continue to tolerate, and indeed even prefer, PAs over NPs because there were some similarities in the training model and we spoke the same language. Now, here we are being eclipsed from clinical roles by others that don’t have the requirement of supervision or the liability attached thereto. And our physician benefactors? Surely there is an upwelling of indignation in the MD and DO communities at the thought of not being able to continue to work with their valuable, similarly trained, highly skilled colleagues? This does not appear to be the case.
The brave position to take back then (and it’s why I haven’t been a member since) would have been to forget titles, retrospective reviews of charts that never saved a life, layers of bureaucracy and rulemaking to try to avoid licensure and accepting (gratefully!) partial payment for services provided competently because we weren’t physicians. The brave position would have been to champion the notion that we know what we know; our experience is what it is; that a chest tube or Swan competently placed is competently placed without regard to the credential of the person doing it; that a diagnosis correctly made or a lifesaving action taken is no less correct or lifesaving for having been done by other than a physician. I’ve delivered babies, diagnosed cancers and potentially lethal cardiopulmonary conditions, held the hands of the dying, run the codes. Physicians do those things too. But I wasn’t better at any of it because somebody somewhere was signing a small percentage of charts a week after the fact and they’re no better at it because nobody supervises them.

I’m a cynic. I applaud you having taken the mental leap required to start the dialogue, and I support it for what that’s worth. I worry that you may not have the resolve needed to push this through.” PA (Maine)

“I recently discovered the investigation into making the PA Profession a full practice authority and responsibility without supervision. I would like to express my concerns with this decision. I am strongly opposed to such a move. I know our profession has in the past competed with Nurse Practitioners and their recent move to a doctorate has concerned our profession, but I do not think it should effect our profession. PAs are still seen by MDs as an affordable, helpful option to their practice and patients still see PAs as helpful team members in getting access to the healthcare they need.

To me it all comes down to the education model. If you want to practice medicine with full responsibility and authority, you go to medical school and get the appropriate degree. That is the only accredited education model for that position in medicine. NPs, though a doctorate degree that claims to produce an independent practitioner, in reality often become part of the team in hospital medicine and in outpatient settings often collaborate with other physicians in the group. Which means in reality there is still no major difference between the utilization of NPs and PAs. PAs have an honored history of being able to practice medicine, under the supervision of a physician, because of the sped up medical model that is our education, supplemented with years of experience in medical fields prior to PA school. It is an excellent option for people who are older, have been working in medical fields and wish to augment their education so they could practice medicine under supervision. If undergraduate students desire to practice medicine they should go straight into medical school. I think our medical education model is only appropriate for our current role as PAs under supervision of a physician. Any appropriate replacement of that education model would be medical school itself. Please do not move forward with any change to our profession that would ruin the great relationship we have with our physicians.” PA (Utah)
“I oppose. PA - MD relationship is important. Also I'm sure some better experience PA's are ready for solo practice, but the bulk of the PAs are unfortunately not. I do not say this to disparage but feel this is true. PAs desiring full autonomy should go to medical school.” PA (Rhode Island)

“Thank you for seriously considering FPAR. This is crucial for PAs in Primary Care. PAs also need to regulate themselves within their states, however we continue to practice medicine unlike NPs who practice nursing. With that said I believe our regulating body should be a subset of the state medical board.” PA (Oregon)

“It’s time is long overdue. We need full practice authority for many reasons. We need it to create a level playing field with NPs for employment. We need it to take the legal stress of our supervising Doctors who have to worry enough about what they are doing, rather than limit our practice to mitigate their legal risks. We need it to thrive and grow professionally. I am a pretty astute observer, If we don’t do this now, I sincerely believe the profession is in jeopardy. I sincerely wish this to be a national initiative and work through the states as our NP colleagues have done. I am willing to donate time and funds to help get this passed in each state.” PA (Ohio)

“I am very happy that you are urging the VA to grant full practice authority to PA’s. I became very concerned when I read this line in the letter on the VA website on how the NP’s are referred to and not the PA’s. It reads as follows: This action proposes to expand the pool of qualified health care professionals authorized to provide primary health care and other related health care services to the full extent of their education, training, and certification to Veterans without the clinical supervision of a physician primary health care and other related health care services to the full extent of their education, training, and certification to Veterans without the clinical supervision of a physician. Since we as PA’s are not given the same extended scope of practice, it implies that we are not (qualified health care professionals). It could not be any clearer. Also I noticed the FPAR is not present on the AAPA web site as it was last week, I’m not sure why. How long would the VA need us if they have to hire a physician for us , and the statement is insulting to our profession as it appears that we are not qualified in the eyes of the public, since this I easily found it without looking for it. I fear that if we do not receive full practice nationwide we as a profession will be at a severe disadvantage professionally.” PA (Virginia)
I have been a PA for 30 yrs. and have worked independently for almost 2 decades in Urgent Care settings. I have worked within hospitals in which there is always a physician available. Presently I work at CVS minute Clinic which is a national organization with clinics in every state. However, only 9 states hire PAs due to the physician supervision restriction and responsibilities associated with this role. I have seen many jobs go to NPs due to this requirement. The nursing lobbyists have greatly influenced their full scope authority regarding job opportunities. We have just seen the VA give full scope authority to NPs which is a major blow to PAs. We need to be competitive in this current market by discontinuing the physician supervision. PAs if in need of some advice, will always consult MD/DOs. We are team oriented but we need to dc this requirement. Also, NPs have an advantage re: their doctorate program in which they can complete online whereas PAs need to attend a brick & mortar establishment. The number of PA annual CME credits outnumbers what NPs need to complete. I feel that PAs are getting left behind and we need to remove an antiquated requirement that no longer benefits PAs in this current marketplace.” PA (New Mexico)

The Bryant University PA Program, faculty, staff, and students fully oppose the proposed AAPA policy regarding Full Practice Authority and Responsibility (FPAR) for PAs. We believe that all aspects of the proposed FPAR policy, with the exception of independent practice created by the proposed elimination of all legal ties to physicians, are already addressed by existing AAPA policy, specifically, the AAPA Model State Legislation for PAs and Guidelines for State Regulation of PAs.

Any current restrictions and limitations on PA Practice that are supposedly addressed by FPAR can be addressed and resolved at the practice level. Concerns regarding supervision, limitations of scope of practice, remuneration, job satisfaction, and providing excellent team-based patient care should not be dictated by law, and the AAPA Model State Legislation provides for such practice-level management.

We believe that FPAR is simply a clever means for remodeling the PA Profession to be one of independent practice and that the elimination of the long-standing, highly-valued partnership with physicians is detrimental to the profession, patient care, and the proven concept of team-based healthcare delivery. One of the most significant issues with FPAR is that since PAs practice medicine and our scope is ideally defined at the practice level, FPAR would leave PAs without any definable scope of practice at all. The legal basis for “practicing medicine” is defined for physicians. If all legal ties to physicians are severed, PAs will be left with no legal ability to practice. An entire new legal scope of practice for PAs would have to be forged in every state, passed through the rigorous legislative process, and adopted and accepted by patients, physicians, hospitals, healthcare systems, and medical practices. It is our belief that this move would set the profession backwards or eliminate it all together, as there would be no legal basis for a PA Profession without physicians.

Some PAs are concerned that APRNs or NPs (Nurse Practitioners) might have job placement advantages because in some states, APRNs are independent practitioners. However, even
though PAs work alongside NPs in many healthcare settings and enjoy the PA/NP teamwork and relationships, NPs practice nursing and PAs practice medicine; this is not an equivalent comparison, and the training is markedly different. Physicians and healthcare organizations may perceive there to be an advantage in hiring an “independent” practitioner because of the inaccurate belief of not having to bear any responsibility for the actions of the NP while having to bear 100% of the responsibility of the PA’s actions. It is more accurate to say that each health care provider (physicians, PAs, and APRNs) are already responsible for actions they take in the course of providing patient care. In fact, there has been no objective evidence presented that NPs are hired preferentially over PAs. We believe that the AAPA Model Legislation which replaces “supervision” with the more accurate term “collaboration” more accurately describes the physician-PA team and individual liabilities. Better served effort would be to enact new AAPA Policy specifically addressing PA liability, physician responsibility, and fair tort reform.

Following the 2016 AAPA House of Delegates Meeting, the discussion of FPAR was referred to a task force, charged with further investigating the implications of FPAR on PAs and healthcare to bring to the 2017 AAPA House of Delegates Meeting in May 2017. At this time, The AAPA Joint Task Force on the Future of PA Practice Authority has not completed any such investigation and has instead put forth the same statements, backed only by anecdotes and individual PA statements and experiences. The Task Force has irresponsibly gone forth with very public messages that have been misconstrued by the public, patients, PAs, physicians, physician professional organizations, and others. Worse, these public discussions about FPAR have made it appear to anyone watching or reading that this is already AAPA Policy and the future of the PA Profession; it is not. Such statements only serve to alienate our physician partners, cause confusion within the PA Profession, and will only make it more difficult to progress the AAPA Model Legislation through the appropriate processes.

The year 2017 marks the 50th anniversary of the PA Profession. At this time, we should be seeking ways to strengthen the already excellent Physician-PA collaborative relationship. Unlike FPAR advocates have stated, there is no basis to believe that PAs have “earned the right” to suddenly become independent practitioners. Any PA practicing in a supportive state legal environment already enjoys the ability to practice autonomously, to the limit of their PA license and training, as part of a health care team. The singular goal of both PAs and physicians should be the delivery of outstanding healthcare to our patients. Bryant University PA Program

Dear AAPA FPAR Committee,

Please accept this letter from the Charles R. Drew University (CDU) Physician Assistant Program in full support of Full Practice Authority and Responsibility (FPAR).

CDU is located in the Watts-Willowbrook area of South Los Angeles, and strives to improve the
health status of underserved communities through medical education and development of medical providers who advocate for social justice and deliver health care through excellence.

I attended the FPAR conference call on January 31, 2017 along with the PA Program Academic Director, Lindsay Kozicz (PA-C) to voice our support of the FPAR initiative.

Specific areas we feel would directly impact our program include:

Improved ability to deliver health care to under resourced areas such as South Los Angeles
- Example of current issue: The new Master of Health Science PA Program launched in August 2016 and since we have worked to develop a mobile van to deliver free primary care to a local substance use/trauma-focused women's residential treatment facility. This project continues to be stalled due to the current restrictions in PA practice without a supervising physician. Supervising physicians have not been willing or able (due to time constraints) to provide their services as a supervising physician.

Hiring in community-based clinics
- Example of current issue: We have visited over 100 surrounding facilities to arrange partnerships for clinical rotations. The major obstacle we have encountered is the preference certain clinics to ultimately hire an NP because of "independent practice authority". This has caused reluctance in affiliation agreements with some clinics, since the ultimate goal would be to hire an NP and not a PA due to the current supervising physician requirement.

Some arguments against FPAR include the reduced length of training time a PA receives compared to an MD. However, the PA educational model is incredibly comprehensive and accelerated, allowing for hands-on training, rather than relying on only bedside training. Our physical diagnosis course for example provides 4-5 hours of instruction two days per week for 15 weeks. The MD model at CDU/UCLA Medical School, for this same course, provides one day of instruction for the entire length of the program, with the intent of providing the rest of instruction during residency.

Having a designated 'supervising physician' does not necessarily result in hands-on training post-graduation. In fact, based on the majority of delegation of services agreements, the supervisory physician is expected to review documentation of 5% of charts on a monthly basis, after the patient has already been seen and treated in the clinic by the PA. The utilization of PAs has always been with the intention of being able to provide care to a wider scope of patients and unburdening our fellow MD colleagues in order to be more efficient and increase productivity. The result of this is often little time spent with your collaborating physician. FPAR does not change the fact that a new graduate needs a mentor. But this mentor, be it a physician assistant or a physician, will need to commit to spending a fair amount of time supervising and mentoring the new PA. This speaks to a greater issue in the profession, rather than specifically to the concern regarding the role of a "supervising physician." We need to push to create more supportive early work opportunities for our fellow, new graduate colleagues. We need to educate our PA students to choose jobs in which they feel supported and have a clear understanding of the orientation process and supervision that will be provided to them during their first 6 months- one year of employment.
There is no argument that collaboration is the key to improved patient outcomes. Collaboration however is everyone's responsibility and is not the result of a designated 'supervising physician'.

Please do not hesitate to contact us for additional assistance of feedback. Thank you again for this initiative!

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“I would like to make one more observation about the proposal. The success of our profession has been in large part a result of the support we’ve received over the years from our physician colleagues. Jeopardizing that relationship risks our professional identity and future. Last night, I heard a handful of personal stories where individuals had encountered challenges related to supervised PA practice. I did not hear a well-reasoned, well-thought out, collaborative approach to a proposal that will have a wide-ranging impact on the PA profession. I would much prefer the organization spend its time and resources providing education and advocacy to inform physicians and employers about the value of PAs (use some of the research quoted last night about similar outcomes between supervised PAs, NPs, and physicians to demonstrate our value to practices) rather than embarking down, what I believe, is a path that will ultimately damage our standing in medicine and our relationship with our physician colleagues and our patients.”  
PA (Massachusetts)

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“I have reviewed the FPAR and it’s policy. I guess I’m still confused on how the Task Force wants to continue a “team based approach” but eliminate the laws or regulations that require supervision or even collaboration with a physician. I did read the AAPA’s article regarding the confusion about if PAs will work without supervision or collaboration (“FAQ: No supervisory agreement does not equal no supervisor”). I know that you state that PAs will continue to work together with physicians to deliver healthcare, but by eliminating the "provisions in laws and regulations that require a PA to have and/or report to a supervisory, collaborating or other specific relationship with a physician in order to practice”, doesn’t it essentially mean BY LAW that a PA can work independently if chooses?

I understand that we need to be competitive with NPs and welcome the need for changes, but I am just seeing contradictions in the policy. I would welcome any dialogue from you for clarification and understanding.”  
PA (Pennsylvania)
"I am a student at Campbell University. I will graduate July 28th (which is a long time coming since I have been in PA school for 4 years, half way through I was diagnosed with leukemia and I had to audit for 2 years)! I just want to say I am so proud of all the changes that are being proposed. From what I have seen in the field I truly believe that having full practice authority is a necessity in our profession. I recently had a preceptor who was forced to change jobs because she couldn’t find a competent and willing supervising physician. This resulted in many issues with continuity of care for the patients.

I just want to say I hope that this passes as we can continue to thrive as a profession!"  PA Student  
Graduating 2017 (North Carolina)

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"As a practicing PA I feel it’s crucial to investigate the FPAR to be competitive in an ever-changing healthcare environment. We will be left in the dust of all other professions that are actively, and aggressively moving forward. One thing that will set us apart from others is by actively engaging our MD colleagues in this pursuit. They may not all agree but if they are at the discussion table they can maybe better understand our rationale."

PA (North Carolina)

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"I think this is a good idea. I think the greatest challenge will be getting states to alter their practice acts."

PA (New Hampshire)

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"I received the survey on full PA practice authority. Although I have not completed the survey I wanted to reach out as I thought I may have a great deal of insight and information that I can provide. As a full practice authority PA (details can come in discussion) I have full understanding and now 3 years of experience in practice ownership. My supervising physician is my silent partner due to that in Colorado a PA can only own 49% of a medical entity. I am 100% owner of a separate S Corp that is a medical management company that operates the practice. I, being the managing partner have assumed all responsibilities of operations for the business. I can speak to all aspects of practice ownership and operations from billing, coding, insurance reimbursement, contract negotiations, human resources, practice guidelines and much, much more. I would love to offer input in any way that I can and if you would find it beneficial to speak I would welcome that opportunity. Upon first entering into practice I wrote an article published in the online version of the PA Professional and after 3 years of blood, sweat and more sweat I have learned, and even struggled with, the business of medicine and how it can impact one's passion for the practice of medicine. The largest area of education I have taken on from self research and patient advocacy within my practice is the struggles surrounding the ACA and how this has so negatively impacted practice operations, revenue, and general patient care.

As I enter into a new phase of my practice by accepting Medicaid in the months to come, my gravest concern is regarding reimbursement issues. I am very gently entering into this opportunity for my community but with grave caution. In the practice world of pay for
performance and quality measures it is certainly going to prove to be very difficult to balance that with the unfortunate truth of Medicaid (as well as Medicare and Tricare) reimbursement driving volume based revenue that allows small private practices such as my own to stay afloat. I look forward to any future discussion and find that I am also interested in becoming part of committee(s) that address these types of issues directly. Although I am not a current AAPA member, I hope this will not deter you from reaching out and allowing me to be a part of such an exciting discussion in the PA profession.” PA (Colorado)

“Respectfully, I have to admit that I believe this push for full autonomy is a terrible proposal and would be of great detriment to the PA profession and to the care of patients. When I graduated from PA school I took an oath to 'do no harm' to my patients. I believe that being forced to give up the collaborative/ supervisory relationship with physicians would certainly create a violation of this oath. How can I provide a physician's service without having the adequate training and degree to do so? I have been practicing as a PA for 10 years and feel no less necessity for the PA-physician relationship today as I did on my first day of work. It is vital to our profession and success. If I were forced to give this up and practice independently, than I certainly believe I would be forced to find a new profession. I would no longer feel that I were trained appropriately for my roll. Simply, How can a person successfully operate in a position that they were not prepared to fill? What nurse practitioners choose to do should have no bearing on us. It makes no difference to me personally and I feel no pressure to be more or less like them.” PA (Virginia)

“Regarding the proposed revised PA regulations. I'm grateful to hear of these. I'm a PA who owns 49% of my practice as that is all Texas allows, my supervising physician does extremely little. I've been feeling uneasy lately as I'm watching my NP colleagues starting their own practices and asking myself why PA's are lagging behind... And I truly believe it's because the power of us to advance or vanish into the night lies solely with the MD's sitting on the medical board. They of course, have their own interests at heart and are fearful we are taking their jobs, we are in certain cases.

NPs are inherently protected from this as they are regulated by the nursing board and the MDs can't really intervene and block progress as readily. I'm fearful if we don't catch up we may lose our bearing and respect as clinicians. I'm grateful for you all advocating for us." PA (Texas)

“We arent physicians and we shouldn't pretend to be. I think creating more bridge programs from PA to M.D. would be a better path to pursue.” Unknown
“I just wanted to drop a quick line to say how amazing the FPAR initiate is for PAs! Thank you for taking on this long overdue task! It would be such an incredible step forward for our profession. Please let me know what I can do to help you!” PA (California)

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“Has serious thought really been given by those who don't already want this done? Treat this like any business branding plan:

1) You have a company that has been around for 50 years.
2) You make Widgets - good Widgets - but even so, the country still doesn't always use your Widgets.
3) You decide to change and update your brand because you feel your Widgets could be used better by more people. If you make bigger Widgets more people will use them.
4) As in any business plan you survey you stakeholders.
5) Stakeholder list is very large, and during your SWOT analysis you identify internal weakness and external threats to your branding plan, as well as the opportunities.
6) In putting together your proposal to the stockholders you ignore the people in charge of the resources to make your Widgets.
7) You seek the opinions from stakeholders who already have decided that that your Widgets should be bigger
8) You do not seek opinions from the largest user of your Widgets to see if a bigger Widget is what they need or can support in their processes.
9) You do not seek buy-in from your largest competitor and see how to work together to both benefit from larger Widgets.

You proceed to build factories, hire people, expend large amounts of capital (financial & political) to make larger Widgets.

Then -which should not be surprising- but will be those who did not do the proper analysis - suddenly your resource suppliers tell you they can not give you all the resources you need because all the good substrate is depleted, and they only have secondary substrate. They don't have the managers to oversee production. Now you are putting together larger Widgets with poor materials.

More important -your primary user of you Widgets- say what the heck, these Widgets no longer fit our machines! We don't have the same use for these Widgets anymore. It would mean changing everything we have done for the last 50 years to accommodate your Widgets. Wish you asked us, we could have told you how to make bigger Widgets that can work better.....not sure we will need your Widgets anymore.

Stupid naive question - did someone/more than one - put together a simple SWOT? The external threats need to be addressed.” PA (Virginia)

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“I'm in support of full practice authority because I am capable of providing care based on evidence based medicine and guidelines like a physician or nurse practitioner. Hospitals and large major clinics are hiring less PAs because of regulations requiring physician supervision. I believe in the team work model of care, however, I am able to think independently about what is in my patients best care and act appropriately given my years of experience in clinical practice. I would suggest a graduated system of practice such that after 5 years of practice a provider earns their full license. New PAs do initially need more supervision because we usually do not do residency programs like physicians. The health care system is burdened enough without unnecessary paperwork related to supervision. Health care is changing and PAs need to get on board with full practice authority because if not we will be a profession that dies out due to cost saving measures implemented by hospitals and insurance companies that care more about their bottom line than the quality of care given by PAs to their patients.” PA (North Carolina)

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“Just a note that I am in opposition of removing 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. I became a physician assistant because I wanted to work in collaboration with MDs, and had no desire to become one myself. I appreciate the supervision, and recognize that I do not have the same training and deeper educational understanding of that of a physician, and, therefore, should not be asked to provide the same level of care as a physician without supervision. I know I am in the minority on this view, but I feel that recognizing that there is a difference between a physician and PA makes me a better provider. I do not feel the agreement makes me any less of a practitioner, but allows me to practice at my fullest capability with the knowledge that I am protected.” PA (Minnesota)

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“I missed the deadline for the survey! But I am in support for the move toward more autonomy practice of PAs as well as a board that would be in direct control of PA credentialing and punishment.

I believe this will love our profession into the 21st century! PA (Georgia)

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“I 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.” PA (Connecticut)

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“I did want to voice my positive support for these changes!” PA (Connecticut)
“I have been a PA for 6+ years. I agree with the pursuit of full practice authority and more autonomy for PAs and I support steps being taken in that process. Thank you.” PA (Minnesota)

“I missed the deadline for the survey, but wanted to provide feedback on the topic. I wholly support the changes for a PA to be able to practice without the requirements of having a supervising physician and limitations to not being able to bill with private and government insurance. I have practiced for the past six years as a PA and have essentially practiced autonomously. I have worked for 3 different companies and not one of them screened patients, so I was seeing the same level of acuity as the physicians and had the same productivity requirements. To me the supervising physician requirement is just a piece of paper and has not done anything to impact how I practice medicine other than require additional paperwork. I currently work at a clinic that employs M.D.’s, NP’s, and PA’s and have participated in the interview process for hiring new mid level providers. It has been my experience that PA’s are less employable, especially as a new grad due to the limitations and I feel this is unfair.

Thank you for your help with advocating for our profession!” PA (Colorado)

“I am in favor of this, provided the collaborative practice portion remains, even if a dedicated supervisor isn’t required. I just worry that employers will leave PAs in situations where there is no one else to touch base with when necessary. I do think it will be helpful to all parties to remove the legally designated supervising physician as this seems to create extra work for everyone.” PA (Minnesota)

“I agree one hundred percent with this concept. In my career as a PA (that now goes for 17 years) I have seldom have a supervising physician that really accomplish that function. Either he/she is breathing under my neck out of jealousy, or work me to death so he/she can make more money, or leave me alone to do all the work while they are involve in R&R, or simply co-sign my charts. It is time to create an incentive to the continues and hard labor of the physician assistant. We do not have any other echelon to grow, so at least, let us be independent like the nurse practitioners, in a collaborative relationship with the MDs.” PA (Texas)

“Aloha! After 25+ years in Hawaii where I have been a politically active PA. And where I helped write the current PA practice rules (which have been amended several times) in 1993-4-5, and where I did battle before the legislature for many years, I have been granted the “PA-C
EMERITUS" status as of January 1, 2017. Though I am no longer a certified PA, I felt it was appropriate for me to participate in this discussion.

I graduated from Duke in 1975 as a "Physician Associate". If I had been seen as an "associate" to the physicians I've worked with over the years, perhaps this sea change at this time would not have been necessary. But it has always been clear that I was an assistant and a subordinate, and somehow required supervision when in many instances, I was the best clinician on site. I am weary of this battle, and I wish all of you great strength and wisdom as you carry the baton. Thank you for your efforts.” PA (Hawaii)

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“As a practicing PA for 10 years and as a faculty member at Augsburg College PA program I have to say my first response to this initiative was “No we don’t need full practice authority; having a supervising MD is our model and it works!” However after greater thought and getting some recent pushback from a possible supervising MD I have completely changed my thought process. We need to be competitive with NPs in the workforce. There is a hospital system here in MN that has become very resistant to hiring PA due to the supervising MD restriction. I have worked in this system in the past and have seen firsthand how NP are deemed better than PAs due to the “independent practitioner” delegation despite having the same clinical responsibilities. We cannot allow ourselves to be limited in this way. I do support the continuation of the team based practice model as you have stated in your policy statement.” PA (Oregon)