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MEMORANDUM IN OPPOSITION
Expanded Physician Assistant (PA) Scope of Practice
H/MH Article VII Part Q

The New York American College of Emergency Physicians (NYACEP) is strongly opposed to expanding PA scope of practice which would allow PAs to practice without the supervision of a physician independently in primary care or in hospitals if they have practiced more than 8,000 hours. While physician assistants are an integral part of the healthcare team, the current care and training model for PAs is with physician supervision. We believe this proposal would fragment patient care and compromise patient quality, safety, and outcomes. The current care model expands the primary care reach at a time when there is not only a shortage of primary care physicians but most health care practitioners.

NYACEP understands the need to address the staffing issues across New York State as well as right-sizing the Medicaid System for reimbursement of services provided. Expanding the physician assistant's scope of practice does not address these issues. A recent study at the Hattiesburg Clinic showed that non-physician lead teams resulted in an increased spending, as well as safety risks, per patient cared for by a non-physician.[1]

The ability for PAs to practice without physician supervision would sacrifice quality for our patients as the training and experience of PAs is not equal to that of physicians. In a recent Medical Society survey, 75% of the physician respondents indicated that advanced care practitioners working independently during the pandemic under the Governor's Executive Orders (waiving physician supervision requirements) had committed an error while treating a patient; 90% indicated that the error could have been prevented had there been physician oversight. PAs have at least 11,000 hours less training in the form of didactic and clinical education in obtaining degrees, and the training is built around a model of supervision with physicians.

NYACEP has long held the best emergency medical care is provided and led by American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) certified emergency physicians. Patients expect care to be given or directly supervised by an emergency physician. This includes all levels and locations of emergency departments (EDs), including rural environments, where there is often a lower concentration of board-certified emergency physicians. NYACEP believes PAs serve an integral role within the physician-led emergency department care team.

Recognizing variations in resources and access, patients should be able to expect the same quality of emergency physician-led care from PAs, regardless of the location and setting of the ED to which they present.

NYACEP believes patients are entitled to receive care and services from health care practitioners who are adequately trained and educated in accordance with provisions of the New York State Education Law to maintain patient safety and quality of care. For emergency physicians, after earning an undergraduate degree, one attends medical school for four years. During these four years, the typical medical student will complete approximately 2,500-3,000 lecture hours and 5,722 clinical hours. Following medical school, to become board certified, one must complete an Emergency Medicine (EM) residency of either three or four years,

which typically includes 6,000-10,000 clinical hours of which 4,225 hours will be spent completing supervised specialty training in the ED. After residency, some physicians may complete fellowship training to further enhance their clinical practice in areas such as ultrasound, critical care, pediatric emergency medicine, EMS disaster medicine, toxicology, and other related disciplines. Board certification in emergency medicine is granted by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Medicine (AOBEM). To become certified, an emergency physician must pass both the written (qualifying) and oral (certifying) exams. Once initially board certified, the physician must then complete ABEM's Continuing Certification requirements to retain certification.

Within this extensive training, emergency physicians are specifically trained to find the needle in the haystack, and the ability to differentiate between a symptom that requires a topical cream, and one indicating more extensive testing and interventions are required immediately. Without that training, a patient that requires a brief visit and minimal testing will result in thousands of dollars in unnecessary tests, or a patient that needs immediate medical care is discharged with a prescription. When a patient presents to an ED with a potentially life-threatening illness or injury, they need care led by an emergency physician.

There have been various studies that have shown that non-physician practitioners order more diagnostic imaging than physicians for the same clinical presentation, which not only increases health care costs but also threatens patient safety by exposing them to unnecessary radiation. In a study by the Journal of the American College of Radiology that analyzed skeletal x-ray utilization for Medicare beneficiaries from 2003 to 2015, *ordering of diagnostic imaging increased substantially-more than 400% by non- physicians, primarily NPs and PAs during this time frame.*

In 2017, after the *American Academy of Physician Associates (AAPA)* passed a resolution on *Optimal Team Practice (OTP)*, the *Physician Assistant Education Association (PAEA),* the only national organization representing physician assistant (PA) education at programs in the United States, issued a statement in opposition to one key section of the OTP resolution on the grounds PA programs may not currently prepare new graduates to practice without "a supervisory, collaborating, or other specific relationship with a physician," and that the AAPA joint task force that developed the OTP proposal had not considered the implications of OTP for PA education. PAEA's surveys of PAEA past presidents, program directors and medical directors found the following:

1. 96% of respondents expressed concern about or advised against full practice authority for new PA graduates. Many commenters went so far as to recommend lengthening PA education, expanding postgraduate residencies, or establishing graduated degrees of autonomy whereby new graduates may, over time, earn full practice authority status.
2. 100% of PAEA Past Presidents indicated PA programs do not prepare graduates to practice without a supervisory, collaborating, or other specific relationship with a physician.
3. 86% of PA Program Directors indicated PA programs do not prepare graduates to practice without a supervisory, collaborating, or other specific relationship with a physician.
4. 89% of Medical Directors (physicians) indicated PA programs do not prepare graduates to practice without a supervisory, collaborating, or other specific relationship with a physician.[2]

In October 2022, a study *The Productivity of Professions: Evidence from the Emergency Department* looked at productivity difference between physicians and nurse practitioners (NPs), two health care professions performing overlapping tasks but with stark differences in background, training, and pay. Using data from the Veterans Health Administration and quasi-experimental variation in the patient probability of being treated by physicians versus NPs in the emergency department, they found, compared to physicians, NPs significantly increase resource utilization but achieve worse patient outcomes. They reported evidence suggesting mechanisms relating to lower human capital among NPs relative to physicians and worker-task assignment responding to the lower skill of NPs. [3]

Finally, in the January 2022 edition of the Journal of the Mississippi State Medical Organization, Batson et al. published an article entitled "Mississippi Frontline – Targeting Value-based Care with Physician-led Care Teams". This was a retrospective study looking at almost 10 years of data from that Hattiesburg Clinic looking at over 300 physicians and 150 advanced practice nurse and physician assistant providers. *The study found that allowing advance practice providers to function with independent panels failed to meet goals in the primary care setting of providing patients with an equivalent value-based experience for quality of care, keeping costs stable and meeting patients' expectations and satisfaction with healthcare delivery.* [1]

In sum, while PAs play a critical role in providing care to patients, their skillsets are not interchangeable with that of fully trained physicians. Patient care would be adversely affected by removing requirements for physician supervision of PAs and this would further deepen the healthcare disparities in our state with unequal levels of care provided in communities.

This would be a very significant divergence from the care model that has been in place in New York since inception. This change should not be hastily enacted as part of the state budget. Rather, much further discussion and objective studies are needed to demonstrate the value and ensure that it does not result in health care costs increasing and most importantly, that patient quality of care is not sacrificed. **For these reasons, NYACEP strongly urges your opposition to this proposal and requests that it be rejected in the budget**

1 Bryan N. Batson, MD, Samuel N. Crosby, MD and John M. Fitzpatrick, MD; Mississippi Frontline – Targeting Value-based Care with Physician-led Care Teams; Journal of the Mississippi State Medical Organization, January 2022.

2 Physician Assistant Education Association, Optimal Team Practice: The Right Prescription for New PA Graduates? May 8, 2017

[3]David C. Chan Jr & Yiqun Chen, 2022. "**The Productivity of Professions: Evidence from the Emergency Department**," NBER Working Papers 30608, National Bureau of Economic Research, Inc.