1. I think it would be a very helpful thing to allow PA’s a little more independence in rural settings. Thank you!

Aaron C. Edwards, MHPA, Superintendent and CEO, Ferry County Public Hospital District #1

2. Since the degree of the “scientist” is the Ph.D., I have difficulty with the terminology, i.e. DMS. Moreover, the coursework does not appear to aim toward a doctoral-level scientist, who must also receive training that is steeped in ethics and philosophy, bioethics, decision theory, advanced research, statistical analysis as well as the generation of an independent research study. Anything less than well-established “scientific” training consistent with the scholarship of a Ph.D. is preparing a “practitioner” rather than a “scientist.” Given the aforementioned concept, the “Medical Degree,” aka MD is already established and assumes that position. All things considered, the title would be “marketable”; however, it would be deceptive to the public. Specifically, the deception would be that a DMS, is a trained “scientist” who may have more training than an MD, when in fact such a person would not be a MD or a PhD scientist. How might this be explained to the public? One troublesome explanation might be that because they carry the title of “doctor,” they have had all the training experiences necessary when in fact, the training is ostensibly “CME” and on the job training, and without the added value of a well-designed socialization experience that makes the “scientist” or launching an independent study. I see this as problematic in the current state it was presented.

Arthur G. Davis, Ph.D., Clinical Psychologist

3. I am very concerned about this proposal to allow physician assistants to practice independently after completing a doctor of medical science program. First, the professional title is confusing and could be easily confused with Medical Doctor. Second, I am concerned about the quality of training, knowledge base, and skill of these doctors of medical science. I am doubtful a person with a doctor of medical science would be comparable to a family practitioner, internist, or pediatrician.

Charlotte Thompson, OT, Occupational Therapist, practicing in home health care.

4. My only contention with this – and it is a big contention – is that the use of the title “Doctor” will confuse the public. See RCW 18.120.030(4)(b), (whether the public can identify qualified practitioners).

Even relatively sophisticated laypeople are already confused by DO versus MD. I have had discussions with other attorneys, for example, who were not aware that a DO is a “real doctor” who has completed medical school, (though I do not mean to suggest that attorneys are “relatively sophisticated”). Many of my clients are already confused about ARNPs and PA-Cs, and are unaware of any distinction as to which are licensed to treat panels independently and which are not.

Given the ARNP precedent, I would support this legislation if the name of the license were changed to “Advanced PA-C,” or “APAC,” with specific language that the licensee shall not use the title, “Doctor.” We already have two separate paths that lead to the level of education and training the public expects of a “doctor.” If the DMS were truly equivalent to a primary care physician, then I would ask whether existing med schools couldn’t merely credit PA-C candidates for certain coursework and clinicals so that a PA-C could achieve the MD or DO with two years of training. If the med schools could
do this, then the DMS is possibly redundant. If the med schools would not do this, then I question whether the DMS is actually equivalent to an MD or DO physician.

Finally, in my humble experience – which admittedly suffers from spectrum bias due to the nature of my work – my encounters with ARNPs and PA-Cs have demonstrated that many are not operating at the same level as MDs or DOs. I’ve witnessed two different ARNPs, for example, who failed to recognize crescendo symptoms of ACS and diagnosed costochondritis and GERD over a period of months until their pts died of CHF. I’ve encountered more than a few PA-Cs with at least a decade of experience in occupational and orthopedic clinics, who fail to understand elementary A&P: Who repeatedly observe annular tears with extrusion of nucleus pulposus, (HIZ on MRI T2 mode at annulus and “candlewax” pattern), who determine that the patient is malingering because pt describes the pain as deep and diffuse, and because the MRI image did not show indentation of exiting nerve root, and pt failed to describe radiculitis with the precision of a textbook dermatome. On questioning, (aside from their non loc sequitur), none of them displayed any familiarity with spinovertebral nerves that innervate the annulus, convergence above the dorsal ganglion, and the fact that inflammation & ectopic impulses generate referred somatic pain – deep and diffuse.

If an ARNP can safely practice independent primary care in Washington, then I would support an advanced PA-C designation who could do the same. We’re already FRSA in much of Washington. But I adamantly oppose using the title, “Doctor.” My $0.02.

Scott E. Rodgers, JD, MBA, Attorney and Counselor at Law

5. As a physician in Washington and Oregon, I am highly opposed to the creation of a doctor of medical science program. We need more physicians with full medical school and residency training, not more shortcuts for undertrained midlevels who under diagnose patients while still managing to over utilize specialists creating a much higher cost to medicine. This is a disservice to our patients, tax payers , and the state and country as a whole I object to this program and hope you will listen and not move forward with such a poor plan. I suggest you start an additional ACGME accredited family medicine residency program if you want more patients to have access to quality healthcare.

Catherine Dalton, MD

6. I as a physician am out raged that this would even be considered! It was a slap in the face to every physician who has gone before and reached for excellence. PAs with a doctorate are in no way equivalent to physicians from a training or education standpoint.

If you are truly interested in improving access to care increase the number of resident positions that are available for our current medical students. You could also allow physicians who are practicing in other countries to come over for those residencies and increase that number. Also you allow physicians who do not have fellowship training in an area to do the same type of on-the-job training that you were well PAs and MPs to do and be paid 80% of that sub specialty. There are many ways to use the positions you have and people who want to become positions and not shortchange their education.

In summary I do not feel it is in the best interest of our country to continue to allow this encroachment of poorly trained individuals who use more resources to be allowed to practice independently. The research studies that have been done in the past were poor and did not take into account that the physicians were taking care of the sicker patients. We want quality not just quantity please help us save that.

Apryl Hall M.D.
In recent years, nurses have pushed to practice medicine independently and in some states have been permitted to do so. Additionally, the American Academy of Physician Assistants has now voted to make it their official policy to seek removal of legal requirements for physician supervision. These movements for full practice authority and responsibility are sold to legislators under the guise of providing access to underserved regions. But, numerous studies have shown that this is far from how these individuals are choosing to practice in reality. For example, in Arizona, where mid-levels have been practicing for 13 years independently, only 11% of those mid-levels set up practice in underserved areas. They used that advertising tactic, exploiting rural Americans, to gain independence and never truly fulfilled that campaign promise. The AMA also has mapping software that allows one to overlay physician distribution with midlevel providers. This consistently shows that these individuals are no more likely to locate in rural/underserved areas. These non-physician practitioners go to the same "desirable locations" as physicians. Clearly the argument of access is a spurious one.

In regard to the argument that these individuals are as equipped to practice medicine, as their physician counterparts, is absurd. Physicians must attend four years of college focusing on basic sciences. These courses cannot be completed online. After completion, medical students must demonstrate a suitable GPA, have high scores on the standardized graduate-level MCAT exam, and then again complete four years of medical school focusing more in depth on human anatomy, physiology, pharmacology and hands on patient centered training in different specialties from surgery and oncology to psychiatry and neurology. Again, none of this can be completed online. After selecting our particular specialty field, we then proceed to 3-7 years of additional training under direct supervision from specialists in our chosen field. Upon completion of that 11-16 year course of education, we must prove our proficiency by passing three 300+ question USMLE exams. Finally upon completion of our specialty residency, we must pass our Board Exams to be deemed competent to legally practice in our field.

Now let’s look at the required education for a nurse practitioner: One can enter a NP or DNP (Nurse Practitioner or Doctorate of Nursing Practice) program after becoming a RN. This can be achieved either via an associate’s degree (2 years post high school) or via a BSN (4 years post high school). It is perfectly acceptable to complete these educational requirements online. And, several programs have a 100% acceptance rate, versus the 5.6% for Medical Schools for the 2016/2017 academic year. There are even now “accelerated programs” that allow entrance with zero previous nursing education or experience. Now let’s consider the content of these online courses. These are from the curriculum of Johns Hopkins DNP program, as in fairness, I want to select a reputable program. Advanced Nursing Health Policy, Organization and Systems Leadership, Philosophical, Theoretical & Ethical Basis of ANP, Health Economics and Finance, Advanced Nursing Health Policy, and the list goes on. This is not an advanced degree in medicine. This is a mid Level degree in health care policy, administration and advocacy. Admittedly, it has served them well.

With all of the differences outlined above, it is clear that NP and PA programs do not have the same rigorous entrance requirements or offer the same courses as medical school, and after 2 years of general study (instead of our 8 + which includes specialization), all three degrees are now intended to lead to the same independent practice in their chosen medical or surgical specialty? They need no post-graduate training (vs. our 4 at a minimum). Then we are all equally functioning "independent practitioners"? Clearly these NPs and PAs are simply taking an easy route and trying to legislate their way into the same level of practice that my medical license confers upon me. If the 14th Amendment guarantees our right to equal treatment under the law, and the State claims the right to pass laws governing the issuance of medical licenses, then the State is required to apply those licensing laws equally. Correct? If the states are granting full practice authority to these individuals based on wildly lesser standards is that not unconstitutional? Why am I now being discriminated against and my license and expertise being underestimated simply because these individuals want what they want? I can’t imagine this doesn’t warrant a class action lawsuit from the AMA or state medical societies against these states and groups? Why are physicians required to maintain Maintenance of Certification? Why have Medical Boards? Why have a medical license at all? Apparently, it's not necessary.
Please note that there is no residency or fellowship required to become a “specialized” nurse practitioner or physicians assistant in any of multiple areas. One simply graduates, has full practice authority and then selects what field they choose to jump into. The same goes for Physicians assistants. "Once you have your PA license, that basically affords you an opportunity to work in any medical specialty," says Chris Hanifin, chairman of the physician assistant program at Seton Hall University in New Jersey. For example: A physician assistant can go from working in internal medicine to obstetrics and gynecology without getting additional training," says John McGinnity, president of the American Academy of Physician Assistants. No physician would be afforded such a luxury, and rightfully so. Now nurse practitioners and physicians assistants have the hubris to claim they are capable of independent practice with only a fraction of the training in a watered-down curriculum. The numbers do not support that assumption. Breaking down hours of training, physicians have anywhere from 20-46 times that of a nurse practitioner and physicians assistant, and in hard sciences, focusing on every aspect of the human body, strict methodological rigor and objectivity, not soft science.

I am a specialist and in the last 9 years, I have seen an explosion in inappropriate management of patients. Disease processes that could have been easily managed by a trained physician, are being mismanaged for months and years, at a tremendous cost to the system, before finally making it to someone board certified and trained to manage them adequately. This is all being done under the guise of “access”. But, what we are now seeing on the frontlines of healthcare is access to lesser trained individuals which translates into poor care for all. In talking with these patients, the majority of them do not even realize they have not been seeing a physician all along, as many of these nurses and pa's with a Doctorate degree, and even many who do not, introduce themselves as “Dr. XX”.

I just want to leave you with one question. When you or your loved one receives that diagnosis that changes your world and puts you at your most vulnerable state, who do you want at your bedside? Do you want a Nurse or Physicians assistant who obtained an abbreviated degree online? Or, would you demand a specialty trained physician with expertise in your specific disease process? You could choose a Doctor Nurse with undoubtedly the #heartofanurse, as this is the slogan they have commandeered. But, please remember, they have the education of a nurse as well. I think we all know the answer to this rhetorical question. Why accept anything less for your constituents?

Apryl Hall, M.D., Cookeville Regional Medical Center Director of Pediatric Hospitalist Secretary and Treasurer of the medical staff

8. Received the same letter from multiple physicians:

As a physician in South Carolina at the VA taking care of our country's veterans, I am highly opposed to the creation of a doctor of medical science program in WA. We need more physicians with full medical school and residency training, not more shortcuts for undertrained midlevels who under diagnose patients while still managing to over utilize specialists creating a much higher cost to medicine. This is a disservice to our patients, tax payers, and the state and country as a whole.

I object to this program and hope you will listen and not move forward with such a poor plan. I suggest you start an additional ACGME accredited family medicine residency program if you want more patients to have access to quality healthcare.

Michele Glass DO
Natalie Sivak, MD
Leenu Pallickal, MD

9. I write you this email to discuss the future proposal of allowing independent medical practice rights to Doctors of Medical Science. I would like to take this opportunity to voice my unequivocal opposition to this measure.
I am a physician. I completed undergraduate studies, medical studies, as well as an internship and a three-year residency in Emergency Medicine for a total of 13 years of post-high school education. During my medical training and residency, I logged well over 20,000 hours of clinical training and research.

Compare this to a physician assistant and nurse practitioner. By comparison, a nurse practitioner has approximately six to eight years of post-high school education. Their clinical education hours amount to approximately 1000 to 1500. A physician assistant has approximately six to six and a half years of post-high school education, amounting to approximately 2000 hours of clinical education. This is at the Masters level.

According to the Lincoln Memorial University Debusk College of Osteopathic Medicine, of which Mr. Moran and Mr. Cushing are faculty, adding the Doctor of Medical Sciences degree (which can be completed completely online according to the announcement on their web site) will add 50 credit hours and no clinical education hours, keeping the clinical education hours at approximately 2000 for the entire educational course.

1500 and 2000 hours do not compared to the over 20,000 hours of clinical education of a physician. This should not qualify them for independent Medical Practice by any means.

While I commend Misters Moran and Cushing as well as LMU-Debusk for wanting to increase the primary care capability of this country, given the critical lack of primary care physicians, I can not believe that providing Primary Care with under trained providers, and giving them full Medical Practice rights, as is suggested by this hearing, is in the best interest of Americans or Washingtonians. I strongly urge you to vote against this proposal allowing full Medical Practice rights to Doctors of Medical Science.

Jonethan DeLaughter, DO

10. As a board certified emergency physician who has spent 4 years undergraduate, 4 years in post graduate medical school training and another 3 years in residency to care for my patients, I am highly opposed to the creation of a doctor of medical science program. We need more physicians with medical school and residency training, not more shortcuts for undertrained midlevels who may confuse patients by using the title 'doctor'. Studies have shown midlevel providers over-utilize specialists and diagnostic testing creating a much higher cost to medicine. This is a disservice to our patients, tax payers, the state and country as a whole.

I would encourage expansion of medical student education and of ACGME residency positions rather than adding another degree to doctor of chiropractic, naturopathic, and/or nurse practitioners that already confuse the average patient. I would ask who you would want to care you yourself or loved ones and contemplate if adding another undertrained degree will benefit the country in any way other than adding the title Doctor that so many of us physicians have poured our life into earning. Expansion of primary care would best be served by expanding current family practice and internal medicine residency positions.

I appreciate your consideration and hope you will vote against this program.

Cheryl Macy, MD FACEP

11. A few comments regarding their Q &A section - I would highly recommend the committee review actual credit hours rather than semesters as this is a gross misrepresentation of medical and PA school being equivalent in education. Moreover, there is no mention of certification process such as the multiple steps of USMLE and board certification (written and oral exams) MD and DOs must pass
prior to graduation and after in order to maintain a license. If this is an equivalent degree, which I highly contest it is not, there should be multiple similar rigorous national examinations in place.

I highly oppose this degree as it will further confuse patients and lessen quality of care. I look forward to further updates.

Cheryl Macy, MD FACEP

12. The idea of independent clinical practice for a "physician's assistant" under the title "Doctor of Medical Science" is a ridiculous, outrageous, and unsafe misrepresentation of qualifications to patients. The definition of a PA is in their title - an assistant - and if "independence" is what is desired then this must be paired with the same intensive training that I did to become a physician. It is a great honor and privilege to care for patients, one that is earned through arduous training - I implore you to not jeopardize patient care and outcomes by diminishing the requirements to serve independently.

Logan D'Souza, MD, Mohs Micrographic Surgeon & Dermatologic Oncologist
Adjunct Instructor, UNC School of Medicine-Asheville

13. Please do not move forward with giving equal practice rights to PAs who complete an online program to earn a doctorate. This is in no way equivalent to a physician who spent 4 years in medical school with structured rotations through all medical specialties, both inpatient and outpatient, followed by another 3-7 years of residency working 70-80 hours per week in the field of his/her choosing to become competent to become an independent practitioner.

The advent of these online schools is not the answer to physician shortages. PAs and nurse practitioners are a valuable part of the team if they are properly supervised, but do not have the expertise to be completely unsupervised as they are not experienced enough to realize when "a horse is actually a zebra."

Taking a 12-18 month online course while working full time is not the same as the additional 2 years of medical school and 3-7 years of residency completed by a physician.

Please do not let them be treated equally as physicians as it will be your family member and mine that suffers from sheer lack if experience.

Thank you,
Tamara L. Crouse, DO

14. This letter is in regards to the DOH consideration of a “new health profession,” Doctor of Medical Science. As a physician, I can tell you that such a program, no matter how well-intentioned, is not “clinical practice equivalent to a medical doctor.” Clinical practice equivalent to a medical doctor is ONLY attained via the rigorous training of 4 years of medical school and at least 3 years of residency. We need more physician with full medical school and residency training. We do NOT need more shortcuts for undertrained so-called “mid-levels” who make dangerous errors in patient care while still managing to over-utilize tests and referrals to specialists, thereby increasing the cost of care. As a specialist, I see inappropriate referrals made by NPs and PAs on a regular basis.

This is a disservice to our patients, period.

If the concern is about patients’ access to quality healthcare, then I recommend that you help to fund an additional ACGME-accredited residency program in family medicine or internal medicine.
15. I write you this email to discuss the future proposal of allowing independent medical practice rights to Doctors of Medical Science. I would like to take this opportunity to voice my unequivocal opposition to this measure.

I am a physician. I completed undergraduate studies, medical studies, as well as an internship and a three-year residency in Anesthesiology for a total of 13 years of post-high school education. During my medical training and residency, I logged well over 20,000 hours of clinical training and research.

Compare this to a physician assistant and nurse practitioner. By comparison, a nurse practitioner has approximately six to eight years of post-high school education. Their clinical education hours amount to approximately 1000 to 1500. A physician assistant has approximately six to six and a half years of post-high school education. They amount to approximately 2000 hours of clinical education. This is at the Masters level.

According to the Lincoln Memorial University Debusk College of Osteopathic Medicine, at which Mr. Moran and Mr. Cushing are faculty, adding the Doctor of Medical Sciences degree (which can be completed completely online according to the announcement on their web site) will add 50 credit hours and no clinical education hours, keeping the clinical education hours at approximately 2000 for the entire educational course.

While I commend Misters Moran and Cushing as well as LMU-Debusk for wanting to increase the primary care capability of this country, given the critical lack of primary care physicians, I can not believe that providing Primary Care with under trained providers, and giving them full Medical Practice rights, as is suggested by this hearing, is in the best interest of Americans or Washingtonians. I strongly urge you to vote against this proposal allowing full Medical Practice rights to Doctors of Medical Science.

Leslie Moore, M.D.

16. I am a physician and I write to oppose this amendment to allow unsupervised practice of PA's. It is both stupid and dangerous. I can't believe anyone would actually consider it

Leslie Moore M.D., Board certified anesthesiologist

17. My name is Dr. Rachel Villegas, DO and I practice primary care medicine. I am writing to voice my opposition to this newly created degree of "Doctor of Medical Science" for PAs. Creating a doctorate degree does not "bridge the gap" for a PA to practice medicine independently as a physician. A physician trains 15,000-20,000 hours to practice independently. Many physicians I know who were formerly PAs cringe at the lack of medical knowledge they realize they had practicing as a PA once they enter medical school and residency. Medical school is 4 years and residency is 3 years (minimum), with some advanced training being many more than 3 years. In residency, a physician is practicing medicine in highly supervised setting with an average of 80 hours a week.

There is an established and highly regulated path to practice medicine independently, which is the path to become a physician. There were 8,000 physicians that did not match into a residency in 2016 as the government doesn't fund enough residency positions for all the physicians that are produced. We do not need to create a new PA doctorate to fill a "physician shortage" as there is not one. We need to create more residency positions.
Rachel Villegas, DO

18. Received the same letter from multiple physicians:

I am strongly opposed to the creation of a new pathway to independent practice for physician assistants. Additional classroom education to obtain a new doctoral degree in no way replaces the 3 years of intensive supervised training that is required of primary care physicians. Physician assistants will not be expected to pass the same rigorous USMLE exams, nor would they be eligible for certification by either the American Board of Internal Medicine or American Board of Family Medicine. Therefore, it is absolutely false to claim that such doctoral level training is "equivalent to a medical doctor in the practice discipline of primary care". Should PAs wish to practice independently, they are free to obtain an MD/DO degree, complete residency training in primary care, and pass the appropriate licensing exams. WA citizens deserve better healthcare than this onslaught by naturopaths, chiropractics, nurse practitioners, and now physician assistant pretending to be physicians, without having obtained the same rigorous training that WA citizens expect and deserve. Instead, I propose the DOH review ways in which it can increase the number of primary care ACGME approved residency positions in the state, in order to attract more medical school graduates. Those who train in the state are more likely to stay and work in the state!

Mehrdad Saririan, MD
Rachel Coe, DO
Kai Wicker-Brown, MD
Katrina Rabinovich
Baharak Tabarsi, MD

19. I am writing to you in regards to the proposal for a new health profession – Doctor of Medical Science

As a private practice board-certified internal medicine physician and married to a private practice board-certified psychiatrist, I have concerns with the competency and training of these individuals for full independent medical practice. They HAVE NOT and WILL NOT have the rigorous medical training involving 4 years of post baccalaureate medical school training and 3 more years of general internal medicine training in addition to any post residency fellowship training encompassing over 20,000 hours of supervised training that physicians have.

What is needed is more residency spots that is currently capped by Congress for the unmatched physicians and foreign medical graduates -- not another profession short of a physician who want to act as a physician. The medical education and training is structured through proper licensing boards with many standardized examinations and superior to that of these shortcut degree fields. Primary care is a difficult field, and not being exposed to the "zebras" and acutely ill patients will leave the practitioner woefully underprepared to distinguish the ordinary from the malignant.

My wife and I have personally witnessed inappropriate diagnoses and treatments by midlevel providers with the potential of harming patients. The training of them pale in comparison to that of physicians, but the raising trend for permitting them to work independently is worrisome to the public who may not know the qualifications of the prescribing midlevel.

Formal medical training is imperative to understand the interaction of body systems, physiologic effects of drugs, and potential side effects that these allopathic medications may have. I will reiterate that the public's health is at stake and approving a new profession will not fill the health gap -- only by opening more residency spots for unmatched physicians will. I may watch with worried interest from afar in Texas, but I am concerned about the well-being of fellow Washingtonians.

Ellis Doan, MD, Chief Medical Officer, Hospital Internists of Texas
20. As a physician, I am both highly concerned and opposed to the creation of a doctor of medical science program. The training of Physician Assistants, without the exact same regulations that Physicians go through (i.e. 4 years of medical school, preliminary boards, 3-4+ years of residency, and specialty board certification including for Family Medicine and Internal Medicine) is not adequate for caring for patients. We need more physicians with full medical school and residency training, not more shortcuts for undertrained Physician Assistants who under diagnose patients while still managing to over utilize specialists creating a much higher cost to medicine. This is a disservice to our patients, tax payers, and the state and country as a whole.

If you take a look at the data coming out of Oregon, Nurse Practitioners who can practice independently are NOT practicing in remote and rural areas, rather they are remaining in the cities where there is NO shortage of physicians.

I object to this program and hope you will listen and not move forward with such a poor plan. I suggest you start an additional ACGME accredited family medicine residency program if you want more patients to have access to quality healthcare.

Christina Girgis, MD

21. This designation would be misleading to the patients, society in general and exposes patients who are most vulnerable to significant physical and mental harm including death.

Primary care, practiced independently and well needs an adequate knowledge base and already developed thought process.

Both would be lacking with this proposal, hence the significant potential for harm.

Hope the department of health can see the rationale against this Poorly thought proposal.

Nitin Jaluria

22. This is a huge risk to public safety. Please look at the clinical work completed for a PA degree. It is inadequate to be an independent provider. Most of their coursework is done online. They want you to believe they are equal to physicians but this is absolutely not true! Please educate yourself before considering letting this happen.

Katherine Breiter

23. I am writing to express my disagreement regarding the Masters of Medicine program. No masters program should and can ever replace MD degree with its attendant medical school and the appropriate residency training. The govt in its zest to decrease the cost of health care in this country is again targeting physicians and trying to push the patients into a dangerous and incompetent model of health care. I hope the govt will reconsider its position on this matter asap.

Dr Humeraa Ahmad-Qamar
24. Dangerous short cut for providing medical care.
   Sahuja

25. It was recently brought to my attention that you are preparing to hear a proposal to create a Doctor of
   Medical Sciences degree for Physician Assistants. The sole purpose of this degree would be to allow
   Physician Assistants to practice independently in primary care. As a primary care physician in
   pediatrics, I am strongly opposed to creation of a pathway to take the assistant and put them in the role
   of a physician.

   With regards to medical training, I completed a 6 year medical program combining my undergraduate
   degree with my MD. I then completed a 3 year residency in pediatrics. My program specifically
   designed hands on rotations that allowed early clinical exposure. My residency involved 80 hours per
   week of hands on training for 3 years directly in a variety of pediatric environments. Even with all of
   that clinical training, I am required to earn 50 CME credits per year, pass board certification in
   pediatrics (which will have to be renewed next year), and maintain a variety of certifications in PALS,
   NRP, and BLS. All of these requirements were put into place to make sure that I am a safe and
   knowledgeable person to treat patients who present to me with illness.

   It is absurd to think that a physician assistant or nurse practitioner can achieve this same level of clinical
   competence with extended classroom or online training. Our medical system is moving towards
   allowing mid-level practitioners to practice medicine independently solely because of cost savings. The
   result of this is that mistakes are made that cost people their lives. The enormity of the responsibility of
   having the health of thousands of children hanging on your shoulders should make a physician's
   assistants take pause. There are many times as a new physician that I found that I couldn’t recognize
   what I didn’t know, and I was guided by experienced physicians in my residency training environment.
   I question whether the newly minted independently practicing physician’s assistant will be responsible
   medicolegally for the mistakes they inevitably will make or if these mistakes will be placed on the
   physician. Finally, when these shortcuts are created to practicing as a physician, what happens to the
   future of medicine? Does the practice of medicine become the practice of “good enough” or will we
   continue to hold those that are responsible for the health or our communities to the high standard
   currently required?

   Christina Peacock MD FAAP, Pediatric Hospitalist, Lawrence, KS

26. I am a physician who is in talks to move to rural Washington for practice. I was recently made aware of
   the Sunrise Review for the Doctor of Medical Science degree.

   I would highly recommend against such a program or license. Although I am still young into my career
   I have seen dozens and dozens of mistakes by physicians assistants and nurse practitioners. This really
   saddens me as patients do not know any better and they trust their provider to have the knowledge to
   practice. Unfortunately, the education of physicians assistants is very limited. It is not suitable for
   independent practice. This new degree does not warrant independent practice. Physicians assistant are
   incredibly important and needed BUT best when working with physicians.

   Many patients do not know who they are being treated by. The uneducated, poor patient will suffer the
   most. They are the ones that need the most help.

   I am very wary of the motives behind the creation of this degree.
Also, do not be convinced by their argument for rural practice. More than 85.3% of PAs work in urban areas with no shortage of medical providers. This chart is from the American Academy of Physician Assistants. It is from their own 2016 Salary Report. I have attached the entire report for your viewing.

To help with the doctor shortage, a better plan would be to consider letting all of the medical school graduates who were unable to obtain residency practice. As considered by bill HB2343 in 2015. These graduates have vastly more experience than PAs.

Harjot Maan, MD

27. I am a physician and I have family and friends in your district. I am extremely worried about Physicians assistants who have a doctor of medical science having prescribing rights. I went to medical school alongside PA students at the top PA school of the time. There is no comparison between the two curriculums- they do not train with the same rigor as the medical students and they definitely do not have the same understanding of the pathophysiology of normal and diseased processes. I am extremely worried about errors in meds - they do not spend as much time learning about drug interactions. It would be very dangerous to allow them to prescribe without passing the medical board exam that medical students are expected to pass. I hope you care about your families enough to shut this down!

Yashica Shah, MD FACOG

28. The sunrise proposal for the Doctor of Medical Science for PAs in unacceptable. The solution for the doctor shortage is not to pretend that PAs are at all equivalent, even with some extra training. Anyone wishing to practice as an MD should be an MD and undergo the necessary training regulated by our medical boards. If a PA would like to attend medical school and become a primary care doctor, then great. I'm not sure why this is even an issue. If I did some online plumbing training and then tried to practice as a plumber, I'm pretty sure that would not be acceptable to anyone. Why is this the case in medicine?

We already have some proposed legislation about allowing medical school graduates to practice (see below). Why not reinvestigate this?

https://legiscan.com/WA/research/HB2343/2015
29. I am writing you to express my concern over the upcoming proposal. While it is necessary to expand our nation's force of physicians, particularly in primary care, it is dangerous to allow non-physician providers to fill this role without adequate structural regulation and individual oversight.

Midlevel providers such as Physician Assistants and Nurse Practitioners play a vital role in the healthcare system, however this role can be more limited in reality than people realize. Recent studies suggesting that the care they provide is equivalent to that of a physician have been based on scientifically flawed methodology. Supervision and oversight are of critical importance for patient safety.

When comparing the education and training involved with mid levels vs physicians, not only are there more years of schooling, but the rigor of the coursework is also quite different. Adding few years onto the pile of someone with an undergraduate or nursing degree does not compare to the 25-30 credit hours per semester of actual medical school. Furthermore, many advanced nursing programs are not tightly regulated, and some of them are even online! This is not the type of education the American public deserves for their sole access to health care. Finally, most of these programs boast 2,000 clinical hours of training that follow the schooling. This is in sharp contrast to medical and surgical residencies; my personal training in surgery residency was 20,000 hours.

Non-physician health care providers absolutely should be respected and valued for their contributions. However, adding the title "Doctor" and a "doctoral degree" is misleading to the American public, especially as most people are unaware of these discrepancies in education and training. Patients should have the right to make their own choices as to whether to see a physician versus a non-physician provider, and new programs to obscure the differences between the two with confusing terminology should be prohibited.

Robin Favor, MD, FACS

30. I am writing to voice my concern and lack of support for the proposal to grant independent practice to physician assistants (PAs) as recommended by Mark Cushing, JD. Doing so would cause multiple issues, as described below. I have personal experience in both supervising physician assistants, and working with them in a “collaborative” setting. While I have loved working with physician assistants, and feel they serve an important role on a multidisciplinary (particularly surgical) team, I do not feel that they should be working without extensive on-the-job training and oversight by their supervising/collaborating physician.

There is already a pathway to provide a physician assistant with independent practice and a doctorate, and it is called medical school. That is the only length of education and training that is minimally sufficient for independent practice.

The American Medical Association does not support the independent practice of physician assistants (http://www.acepnow.com/article/ama-president-dr-steven-stack-talks-physician-shortages-and-apps/). PA literature demonstrates that most practice in urban areas, so they are not a solution to a perceived lack of access (see attached). And physicians know that increasing access does not mean increasing actual care.
Only currently-practicing physicians should be allowed to bring proposals regarding medical practice to the State, as the results will (theoretically) affect themselves, as well as others – not those of a completely different field, which stands to profit off increased litigation stemming from increased PA lawsuits, which will necessarily accompany this legislation. It is unclear why Mr. Cushing is trying to pass what he repeatedly referred to as “my” plan, and “my” proposal at a Tennessee Medical Association meeting that was described by one physician in attendance as a “disaster.” One has to wonder how he benefits from this scheme.

As no rational being can compare a physician assistant’s education and training (or lack thereof) to a physician’s, one can only surmise that their career field is growing and attempting to expand its scope of practice for financial reasons. They are not cheaper, as an actual physician inevitably has to cover for their lack of knowledge. They don’t know what they don’t know, tend (in my experience) to be consistently over-confident, and represent a real danger to patients. In my experience I have had them fail to recognize what I would consider common medical terms and conditions. I could provide multiple examples where a physician assistant practicing essentially without supervision (even in states which require supervision) exhibits everything from a serious lapse in judgment to causing the death of patients (none of whose care should have been handled by a physician assistant, yet they were too ignorant too know when they needed help).

One could just blithely approve this scheme, as long as PAs carry their own malpractice insurance, which should be greater than that carried by physicians, as they are doing the same job with significantly less training. However, this would not prevent harm to public, which is my primary concern. Some physicians are refusing to train PAs, with the thinking being that we should not be training (usually unpaid, often even without our prior consent) our lesser-educated replacements. However, I am not sure that is the right answer either, as it does little to improve patient safety, which is the ultimate goal.

Physician assistants have their place in a team-based approach to medicine, particularly in the surgical fields, where they can be trained to assist in specific procedures, but it is not in an unsupervised role. In my experience, in the non-surgical field, they need to be very closely monitored, and as such do nothing to save the healthcare field money, improve access, and they certainly do not improve safety, regardless of the ill-constructed literature they attempt to provide to the contrary.

We all should acknowledge that they are not safe as they currently practice. We need to increase supervision, rather than withdraw it, as this is the only way we can increase patient safety.

Noah Gudel, D.O.
Same letter also sent by:
Emily Marmarou, D.O., Pediatric Resident OGME-2, Wyckoff Heights Medical Center
31. I am writing to oppose the "Doctor of Medical Services" for PA's proposal. Allowing PAs to practice as physicians is not an adequate alternative to the supposed physician shortage. PA's are not regulated in the same way MD/DO physicians are. Nor do they have possess the education or degree of training of physicians. This poses a detriment to patient care. Please reconsider this proposal.

Julie Humsi

32. I am writing to express my disappointment in the WA State DOH for choosing to address a perceived Physician shortage by allowing Physician Assistants unearned title and independent practice rights. The burden of proof for me to obtain and maintain an allopathic Physician license in WA State is tremendous - and rightfully so.

This bill proposes to create a double standard or two-tiered system of care in WA State: care from appropriately trained, experienced, licensed physicians and care from inexperienced, minimally trained physician assistants.

WA State has taken good steps to address Physician shortages, particularly by opening a second allopathic medical school. The next steps should focus on increasing internship and residency training positions, particularly in primary care specialties (FM, IM, Peds, OBGYN), not on giving PAs the ability to call themselves "Doctor" and practice independently.

I sincerely hope that this bill gains no traction and the WA DOH and legislature can focus efforts on other, more appropriate methods to improve access to care in WA State.

Cristin Mount, MD, (Internal Medicine/Critical Care Medicine)

33. As a physician, I am highly opposed to the creation of a doctor of medical science program. We need more physicians with full medical school and residency training, not more shortcuts for undertrained midlevels who under diagnose patients while still managing to over utilize specialists creating a much higher cost to medicine. This is a disservice to our patients, tax payers , and the state and country as a whole
I object to this program and hope you will listen and not move forward with such a poor plan. I suggest you start an additional ACGME accredited family medicine residency program if you want more patients to have access to quality healthcare.

I am strongly opposed to the creation of a new pathway to independent practice for physician assistants. Additional classroom education to obtain a new doctoral degree in no way replaces the 3 years of intensive supervised training that is required of primary care physicians. Physician assistants will not be expected to pass the same rigorous USMLE exams, nor would they be eligible for certification by either the American Board of Internal Medicine or American Board of Family Medicine. Therefore, it is absolutely false to claim that such doctoral level training is "equivalent to a medical doctor in the practice discipline of primary care". Should PAs wish to practice independently, they are free to obtain an MD/DO degree, complete residency training in primary care, and pass the appropriate licensing exams. WA citizens deserve better healthcare than this onslaught by naturopaths, chiropractics, nurse practitioners, and now physician assistant pretending to be physicians, without having obtained the same rigorous training that WA citizens expect and deserve.

Instead, I propose the DOH review ways in which it can increase the number of primary care ACGME approved residency positions in the state, in order to attract more medical school graduates. Those who train in the state are more likely to stay and work in the state!

GEORGE DAVIS, MD, FACEP, Regional Medical Director, Christus SETX
Site Medical Director, Christus St. Elizabeth

34. I am writing to voice my concern and opposition to the proposal to grant independent practice to Physician Assistants (PAs).

Physician Assistant Education Inequality with Physician Education:

I have worked with Physician Assistants as part of my practice for over 10 years. They serve an important role on our team, and I value their educational model. However, they should not be working without extensive on-the-job training and oversight by a supervising physician.

One simply cannot possibly learn the breadth and depth of knowledge needed to practice medicine independently after completing a 27 month program, which is the length of training a PA receives.

Post-graduate medical education: 27 months for a PA vs 7-14 years for an MD/DO. (I omitted undergraduate years for both groups, as undergraduate programs are not “medical” training.) It is absolutely impossible that anyone with 27 months of education in any field can be equivalent to anyone with 7-14 years of education in that same field.

There is already a pathway to provide a Physician Assistant with independent practice and a doctorate, and it is called medical school.

AMA and State Medical Associations Do Not Support Independent Practice for Physician Assistants:

The American Medical Association does not support the independent practice of physician assistants (http://www.acepnow.com/article/ama-president-dr-steven-stack-talks-physician-shortages-and-apps/). In addition, there are no state medical associations that support independent practice for Physician Assistants.

Physician Assistants Do Not Practice in Rural/Underserved Areas:
The motivation for many legislators to support independent practice for PAs is because they expect PAs to fill a need in rural and/or underserved areas.

However, American Association of Physician Assistants (AAPA) data demonstrates that the vast majority of PAs practice in urban areas, so they are not a solution to a perceived lack of access in those areas (see attached).

The Solution is More Physicians:

Instead of lowering standards for the independent practice of medicine, please consider these options:

- Working to increase the number of residency positions available to graduating medical students: In 2017, 8,640 graduating medical students found no residency position available to them. That’s nearly 8700 physicians who won’t be practicing medicine anywhere, despite their lengthy education.
- Increase incentives for practicing in rural/underserved areas: Physicians graduate with staggering student loan burdens. Finding solutions that help alleviate that burden and increase the number of physicians practicing in rural/underserved areas is critical.

We all have the same goals: patient safety and access to excellent care.

GEORGE DAVIS, MD, FACEP
Regional Medical Director, Christus SETX, Site Medical Director, Christus St. Elizabeth

35. I am writing to express concern regarding to the proposed legislation for a "Doctor of Medical Sciences" for PAs. I practice in Portland, Oregon with many patients from Washington, therefore this is of specific concern to me and my patients.

There is certainly a shortage of qualified physicians in the United States. However, there are thousands of physicians who were unable to match into a residency. According to the NRMP this number is over 8000 and getting worse every year. These are physicians, graduates of medical school who are unable to practice independently. The long term solution to the shortage of providers should be two fold- 1. Increase the number of residency positions for qualified MD and DO students. 2. Create a pathway for independent practice for physicians (MD/DO) who have not completed a residency. There was proposed legislation regarding the second point which did not move forward.

Physician assistants have a very important role in healthcare. However, this doctor of medical sciences proposal is not the answer improving access to qualified providers. A new medical school has just opened in the state of Washington. Have residency spots increased? If not, opening more schools, regardless of the credentials provided is irresponsible to these medical students, many of whom will go into significant debt to acquire the most comprehensive medical education. Any person in health care who wishes to become a physician should apply to medical school and meet these rigorous standards to practice independently.

Amitha Ananth, Pediatric Neurologist, Geneticist

36. I am writing to testify against the proposal for this new degree. This is incredibly confusing for patients, their family members, and will grossly jeopardize patient care.

As a physician, I am both highly concerned and opposed to the creation of a doctor of medical science program. The training of Physician Assistants, without the exact same regulations that Physicians go
through (i.e. 4 years of medical school, preliminary boards, 3-4+ years of residency, and specialty board certification including for Family Medicine and Internal Medicine) is not adequate for caring for patients without supervision.

This is a short-cut for under-trained Physician Assistants to under AND incorrectly diagnose patients while still managing to over-utilize specialists creating a much higher cost to medicine WITHOUT the supervision of a physician. This is a disservice to our patients, tax payers, and the state and country as a whole. Quite frankly this is also very much so a slippery slope and will lead to an even more confusing health-care setup than there already is!

If it is expected that the people who are granted this degree will stay in under-served rural areas.....think again. Take a look at the data coming out of Oregon, Nurse Practitioners who can practice independently are NOT practicing in remote and rural areas, rather they are remaining in the cities where there is NO shortage of physicians.

Lastly, the primary applicant for this proposal, Mark Moran, has not practiced medicine since 2013 (according to his CV, which I attached to this email). I fail to see how a person who does not practice clinical medicine has any experience to establish a doctorate program let alone be in a position to propose that other PAs be able to practice medicine independently.

I object to this program and hope you will listen and not move forward with such an egregious plan.

Bethany Lema, MD

37. I am a concerned physician writing to express my strong opposition to House Bill 1771, that would allow non-physicians to engage in the practice of medicine. Such a change would not expand access to health care; it would increase the cost of health care and it would not be safe for the people of Washington. Please do not support House Bill 1771.

Although physician assistants have a vital role in health care, they do not have the same education and training as a physician. As a wife to an excellent P.A., I am well aware of the breadth and depth of their education. Their training is only a fraction of that of an M.D. or D.O. Allowing physician assistants to provide patient care without physician oversight is simply not safe. To suggest that this doctorate program would be equivalent to that of a medical doctor in primary care is absurd. That statement alone speaks to the absolute lack of information used in consideration of this bill.

Thank you for your time and consideration of this matter. Feel free to reach out to me if you have questions about my stated concerns.

Wanda J. Abreu, M.D.

38. Physician assistants cannot practice as medical doctors. They have no basic training and have a lot less clinical acumen than a 2nd year medical student at graduation from medical school. 2 years of clinical shadowing with PA school does not equate to adequate training to care for patients. There is a reason mortality increases significantly in July of every year (due to newly graduated doctors, and these doctors of 4 years of real clinical training). How can you trust life to PA?!!!
Naming PAs as "doctors" is false advertisement. They are "assistants" for a reason. A pcp's job is to limit medical spending not to consult all services for management of simple issues. All PAs do is learn how to consult for any abnormality which basically is like training a monkey.

If PAs can practice independently than I propose MDs can also right after graduation from real medical school!

I am COMPLETELY against this sunrise proposal as it will lead to poor patient care, more deaths, more missed diagnoses, and way more medical spending.

Dr. Isabella Lai

39. As a physician, I strongly believe the "proposal for new health profession – Doctor of Medical Science" is an incredibly inappropriate proposal and very dangerous to patients. Not only would it's passage be confusing to patients trying to determine who is a true medical doctor (MD) vs a provider with vastly less training, thus allowing for significant misrepresentation, this proposal has the potential for patient harm. Under no circumstances should a PA be considered equivalent to an MD because they are NOT equivalent in terms of training and expertise. This proposal attempts to equate the two as equal. Obtaining an MD degree is vastly more rigorous, and with that rigorous background comes superior patient care versus lower level providers. This should not be surprising given the time, effort, and sacrifice put into obtaining an MD degree. There is a place in healthcare for lower level providers, of course, but that is under the supervision of a physician. This proposal should not, under any circumstances, move forward. I urge you to vote NO.

Emily de Golian, MD

40. I am writing to voice my concern about the PA Doctor of Medial Sciences proposal. This is VERY DANGEROUS. This is purposefully and with intent trying to confuse the patient. THIS IS GROSS PATIENT NEGLIGENCE.

PA school is significantly easier to get into than medical school. PA students have limited training - often trained by one physician, and should be allowed to practice ONLY with supervision. PA school is often taught by other PAs. My sister who is a PA spent her outpatient rotation with a NP owned solo practice - midlevels training midlevels - VERY DANGEROUS.

It is challenging to become a physician or in the medical community a "doctor," and it should be. We are discussing patient care and someone's life. I have seen numerous examples of mismanaged patients by PAs. This bill will only make it easier to confuse the patient.

I STRONGLY recommend that you say NO to this proposal.

Please feel free to contact me.

Kendall Egan MD

41. I am a board certified emergency physician, and am writing in opposition of your proposed independent licensing of physician assistants with a doctorate degree.

I have been a practicing emergency physician for 15 years, and have trained and staffed many PAs. I was the medical director for one of the sites for the Interservice Physician Assistant Program, the largest PA training school in the nation.

While PAs can be a valued part of the healthcare team, their training does not prepare them for independent practice. To place them in this situation leaves them and their patients vulnerable.
PA students complete 2000 hours of patient contact time in school. A physician in training completes that amount of contact time in less than one half a year of medical school. Three more years of medical school, plus residency, results in an over 6 fold increase in patient contact hours for physicians. Medicine is both an art and science, and requires practice. PA school, even with their graduate level degrees, simply does not contain enough patient contact hours. Nor does it contain the basic science underpinnings to understand disease processes like a physician is able to.

The easiest way to think about this is an orchestra. You can be a great tuba player, but a horrible conductor. Every orchestra needs a skilled conductor to make beautiful music. Every health care team needs a physician to coordinate safe patient care.

Please do not jeopardize patient safety by allowing PAs independent practice. As a physician, I would not allow my family to be cared for by an unsupervised PA, and that should give everyone pause if the people who know best shy away from this type of provider.

Torree McGowan, MD, FACEP

42. I am writing as a concerned physician who was previously a physician assistant. The discussion to allow PAs to practice independently after completing the Doctor of Medical Science degree is deplorable. This is a matter of public safety. Time and time again, midlevel providers have demonstrated that they are not interested in serving in rural areas but instead are intent to be physicians without doing the necessary training. Even with the additional "training," PAs will still be ill-prepared to work independently of physicians. The differences in training for PAs and physicians is vast- I would know as I have done both! You simply cannot know what you do not know until you go through extensive training. The proposed curriculum is, for lack of a better phrase, a joke. They state their primary text will be MKSAP, a review text for the internal medicine boards, not even a primary text! Primary care is one of the most difficult specialties in medicine. After completing PA school, 2 years in clinical practice, 4 years of medical school and 1 year of internal medicine residency, I still request attending assistance for 3/7 of my scheduled patients today! It is frankly insulting to suggest a PA could be a PCP. I hope you will reject this proposal.

Additional comments added after the department shared applicant group responses to our applicant report follow-up questions

In light of this new/added information, I'd like to add one comment to my prior letter. There is a blatant lie in the FAQ about PA education being 4 semesters of didactics and 1 clinical year. It is only 2 full semesters and 1 summer (6 week semester) of didactics. I completed my Masters in PA Studies so I would know. Further, there is also a deception in the FAQ. Equating 3 years of PA clinical experience to residency is appalling. Most PAs work about 40 hours/week while physicians work approximately 72 hours/week for those 3 years. This is nearly double the time. The fact remains that the lack of knowledge that is taught only in medical school and provides a fundamental base required for competent independent practice will never be achieved through a PA training program or degree, and certainly not by one that uses a review text as its primary text.

I've done more research and found yet another deception in their FAQ which is a major game changer. They claim they are the only program but Lynchburg College is also starting a DMS degree program-this is completely online and is only 9-12 months long!

https://www.lynchburg.edu/graduate/physician-assistant-medicine/doctor-of-medical-science/

Christin Giordano, MD
43. My name is Dr. Matt Messa. I am writing on behalf of my beloved friends, family, and fellow Navy colleagues who still reside in the great state of Washington.

I am an emergency physician but uniquely I am also a former physician assistant. The idea of giving PA's independence is beyond insane and dangerous to the citizens of your great state. After being a physician assistant, it took me seven long grueling years of medical school and residency to be allowed to practice independently as a physician.

This is a fringe movement of the PA profession and will only undermine the PA-physician team while endangering the health and lives of Washingtonians.

It is not all that uncommon for PA's to go on to medical school, and those who have done it realize how much PA education leaves out. No matter how you spin it, you cannot compare two years of PA education to the minimum of seven involved in physician education and residency.

Thank you for your time and for keeping Washingtonians safe!

Dr. Matthew J. Messa DO, FACEP

44. In reply to the "reply" regarding bridging the gap from PA to physician, the response is weak at best. Expecting that years of practice make up for knowledge gaps is simply not true. Ask us who gave completed both curriculum. I have researched this extensively and there is at least an 18 month knowledge gap between the two professions that cannot be made up by work experience. Work experience can be any specialty, and brings with it no objective measures of proficiency. And that 18 month difference in basic education is only the beginning. Physicians then complete a residency working nearly 80 hours per week where they must undergo weekly lectures and complete a board exam every year to go on to the next level. At the end of residency physicians must pass their individual specialty board certification to practice independently. This proposed curriculum is all smoke and mirrors. There could be a way to build a bridge between PA education and physician education but the well researched best estimate to make this happen would require four and one half years of intense didactics, residency, three separate national licensing exams and residency specialty specific board exam. There are no shortcuts to safe independent medical practice. I cannot even imagine why legislators themselves would feel anywhere near qualified to consider this absurd proposal without the buy in from the state medical board. Please do not endanger Washingtonians by approving this ridiculous proposal. The vast majority of PA's realize this is a fringe ridiculous proposal that undermines the relationships between physicians and PA's.

Dr. Matt Messa

45. I wanted to give you and fellow legislators a simple analogy as to the absurdity of this bill.

Imagine if a paralegal society decided outside the state Bar that they were developing a path to equality with attorneys that would be a curriculum created by them with one attorney sponsoring it. This path would give credit for a few years of service and then be exempt from taking the Bar exam. I'd like to believe that attorneys would have nothing if it.

Physicians take not one but three distinct "Bar" exams followed by one granddaddy "Bar" exam which is their individual specialty board exam. Each exam is a standardized, well studied and vetted exam that is given at specific times in their academic progression. Every physician must pass each one to practice independently. Any person who seeks to independently practice medics should be required to show minimal proficiency by passing these exams.
If a group of PA's wants to work out a path to independent practice that allows for taking these exams, you may experience significantly more buy in from physicians and medical boards. This would require cooperation with, not behind the backs of state medical boards. Anything less would be tantamount to the ridiculous path I described above of paralegals. I mean does Washington really want to set legal precedent that any profession seeking to obtain the practice rights of a more educated profession need only create a work around? Where will this end? Will engineers, pilots, nursing, or electricians be next? Our society was built on standards and to dilute them would mean it's ultimate collapse. Third world countries have weaker standards for professionals but even they stand by those standards. Do we want Washington to be less civilized than third world countries?

Dr. Matthew J. Messa, DO, FACEP, Board Certified Emergency Physician.

46. I am a physician in Oklahoma. I am originally from the State of Washington and my husband and I plan to return to the state in the next few years.

However, I am very concerned about plans to possibly provide freedoms for independent practice to Physician Assistants. I work directly with 3 PAs in my current practice. They are a wonderful support and a boon to the ER. However, they practice within their title -- as assistants to the physicians. They have the training and knowledge to provide cursory exams and provide a generalized differential diagnosis. They are not able to understand nor are they trained to see the complexities of individual patient presentations. In medical school we are taught that diseases do not read text books, only medical students do that. What this implies is that each patient will present with their own complexities and individual presentation, even with common illnesses.

I currently work in a state where all but 2 counties are considered medically underserved. I understand the need for more doctors, trust me. I see patients daily who do not have ready access to physician care. That being said, I have seen far too many patients who have been mismanaged by PAs and NPs alike. Oftentimes, these physician substitutes are not being appropriately or directly supervised. This is a threat to patient safety as well as a threat to the very structure of our American medical system. The talk in politics currently is that there is too much money being spent on health care. There are so many contributing factors to this that neither of us has the time to delve into currently. But one of the biggest contributions I see to overspending are the excessive tests and admissions made by midlevel providers. Physicians have a different understanding of physiology and treatment of disease that just is not addressed or taught in PA / NP schools.

I urge you to re-consider approving PA independence. It is a danger to patient heath and our health care system as a whole. If you have questions you wish to address, please feel free to contact me.

Alicia Apple, DO

47. I am very concerned about NP's and PA's pushing for independent practice. This is not safe for patients, including your family, my family and everyone.

I was an RN before I went to medical school. The difference between nursing education and medical education cannot be over emphasized. Midlevels do not have the years of experience in residency where you are mentored by attendings for years and taught the science and art of medicine. There is also a level of responsibility that you obtain as a resident physician which we take to heart and learn how important knowing your medicine is. A life will depend on it.

While PA's and NP's play roles in the healthcare team that are important, they cannot be allowed to practice medicine by diagnosing and prescribing without supervision.
NP's started out denying they wanted independent practice and now they and PA's are both trying to become independent. PA's are afraid they will be passed over for jobs if NP's do not require supervision but they do. Corporate medicine is all about the bottom line.

This is not about jobs. This is about safe health care.

There is a shortage of primary care physicians. We need more well trained physicians, not more midlevels pretending to be physicians.

Cheryl Ferguson MD

48. In recent years, the American Academy of Physician Assistants has voted to make it their official policy to seek removal of legal requirements for physician supervision. These movements for full practice authority and responsibility are sold to legislators under the guise of providing access to underserved regions. But, numerous studies have shown that this is far from how these individuals are choosing to practice in reality. For example, in Arizona, where mid-levels have been practicing for 13 years independently, only 11% of those mid-levels set up practice in underserved areas. The AMA also has mapping software that allows one to overlay physician distribution with midlevel providers. This consistently shows that these individuals are no more likely to locate in rural/underserved areas. These non-physician practitioners go to the same "desirable locations" as physicians. Clearly the argument of access is a spurious one.

The argument that these individuals are as equipped to practice medicine, as their physician counterparts, is absurd. Physicians must attend four years of college focusing on basic sciences. After completion, medical students must demonstrate a suitable GPA, have high scores on the standardized graduate-level MCAT exam, and then again complete four years of medical school focusing more in depth on human anatomy, physiology, pharmacology and hands on patient centered training in different specialties from surgery and oncology to psychiatry and neurology. After selecting our particular specialty field, we then proceed to 3-7 years of additional training under direct supervision from specialists in our chosen field. Upon completion of that 11-16 year course of education, we must prove our proficiency by passing three 300+ question USMLE exams. Finally upon completion of our specialty residency, we must pass our Board Exams to be deemed competent to legally practice in our field.

PA programs do not have the same rigorous entrance requirements or offer the same courses as medical school, and after 2 years of general study (instead of our 8+) this "Doctor of Medical Science program" purports "to train physician assistants in advanced clinical medicine and prepare them for clinical practice equivalent to a medical doctor"! I'm sorry, changing the name of your abbreviated course of study from Masters to Doctorate, does not a medical doctor make. This is nonsense. Clearly these PAs are simply taking an easy route and trying to legislate their way into the same level of practice that my medical license confers upon me.

Please stop contributing to the dumbing down of healthcare. We (physicians and constituents) have had enough.

Tanda N. Lane, M.D.

49. I am writing in strong opposition to the proposal to create a new health profession entitled “Doctor of Medical Science”.

I am a family physician working at the University of Washington. In my role, I have worked for years with physician assistants, including many faculty and graduates of the MEDEX physician assistant program based at the UW in multiple sites throughout the state.
I strongly support the benefits of having physician assistants as part of the health care workforce, and respect the many skills they bring to patient care. However, their skills are best and most safely employed WITHIN the current rules of working under the indirect supervision of a physician. They do not have, nor does this new model include, anywhere near the years of training and practice experience required of physician training. Creating an independent role for persons with inadequate training to provide that level of care would create significant patient safety errors; inefficiencies and increase costs of care as these providers have been shown to INCREASE referral rates to more expensive specialists because of their own limited training in understanding and managing any level of complexity in patient care; and the majority of graduates of these programs have also been shown to NOT go to areas of patient care workforce imbalance, but to stay in urban areas.

I understand that the needs of rural communities for primary care services in particular is increasing. However, creating an unsafe solution is a disservice to those communities and those patients.

Thank you for requesting input into this critical decision.

Judith Pauwels, MD, Professor
University of Washington School of Medicine, Department of Family Medicine

50. I am A CALIFORNIA licensed family physician but immediate family live in Washington. This bill to allow physician assistants practise independently is a fringe movement of the PA profession and will only undermine the PA- physician team while endangering the health and lives of Washingtonians.

A direct comparison of two years of PA education to the minimum of seven involved in physician education and residency are not minor. I hope you will consider the safety of Washington residents above all else in your decision making process.

Thank you for your time and for keeping Washingtonians safe!

Evelyn Darius, MD, FAMILY MEDICINE

51. Please accept this email against the idea of allowing physician assistants to practice independently via training outside of medical school. the "Doctor of Medical Science" will not prepare physician assistants to practice independently but instead expose them to complicated health scenarios without proper supervision.

I currently work with a PA in my psychiatry practice and he's phenomenal. He recognizes that my supervision and support make the job safe and enjoyable and he has said repeatedly that he has no desire to practice on his own because of these factors.

If I can be of assistance in helping explain further, please don't hesitate to let me know. While I'm not in Washington state, this conversation is being had across our country.

Brian J. Dixon, M.D., Executive Director, Progressive Psychiatry, P.A.

52. I am a practicing Family Medicine Physician who grew up in Snohomish. Most of my family are in the Olympia area.
I just found out that Washington is trying to implement a doctor of medical science degree which would pave the way to Physician Assistants being licensed to serve as primary care providers. I vehemently oppose this implementation due to its apparent lack of respect for, and understanding of, the complexity, experience and knowledge needed to be licensed in my profession and due to my concern over patient safety and care.

I hope we can agree that this particular doctoral degree would confuse patients, policy makers, the general public, and the occasional busy physician specialists into thinking that these "doctors" had the same level of education as Family Medicine or any board certified Physicians.

Who stands to benefit from this line blurring?

I can tell you that Family Medicine is complicated and there are no short cuts to learning what a physician must know. Those who serve as primary care physicians must go to undergraduate school, medical school, and residency. We must pass entrance and board exams all along the way as well as keep proficiency after they are board certified. We are taught by physicians who have gone through the same standard of education process. This process has worked well for decades and the only thing in my opinion needed to improve this process is to open up the possibility for more Physicians through the same education but I digress as that is another issue facing physicians and public safety at this time.

Anything less than full medical training in order to have the right to be called and function as a doctor in the clinical setting is providing a disservice to the patients of Washington State. It is also a real blow to the morale of primary care physicians who have worked very hard to get where they are and to provide excellent care to the people of Washington State. Fewer people will want to become Physicians if they can take these kinds of shortcuts and I don't think it will be too many years before the effects of that snowball and really start to hurt patients when those who are supposedly their doctors do not know everything they should know in order to be in that position.

There is a definite problem and shortage in healthcare but I do not believe that breaking up the team, confusing the idea that all parts of the team are equal in knowledge and experience, and further demoralizing the precious few physicians we have is the answer.

And again I ask, who stands to benefit from this line blurring?

Elizabeth Hatz, D.O., Board Certified Family Medicine

53. I am writing in regards to the Doctor of Medical Science bill (WA) to express my strong opposition to the creation of a new profession which would allow physician assistants to be the "equivalent of physicians." As a physician and member of the public who is well-informed of the vast difference in training who receives care from a primary care physician, I believe only physicians who have their MD or DO should practice medicine independently. There are other, more safe avenues to address the primary care shortage. This is a slippery slope which will only lead to PA independent practice which, to be frank, is unacceptable. This degree consists of a 1 year online curriculum using a board review text followed by 1 year of supervised practice. This is no where near what internists complete. An internist completes 4 years of college, 4 years of medical school and 3 years of residency before they are allowed to practice. A specialist like myself has an additional 3 years of fellowship training. There is absolutely no comparison in level of training. You simply cannot know what you do not know. My fear is that primary care, which is one of the most complicated specialties, is being relegated to "just primary care." In addition, patients who seek care and are introduced to a PA as "doctor" will assume they are receiving care from a fully trained physician. This constitutes fraud in my opinion. I hope this bill does not pass and that you will stand up to protect patients.
Aileen Mickey, MD, FCCP, Pulmonary and Critical Care Physician

54. I am AGAINST allowing the independent practice of physician assistants/doctor of medical science. The training simply does not prepare them for independent practice. An MD with one year of residency after graduating medical school would be more prepared.

Christine Coleman, MD

55. I am writing to voice my concern and opposition to the proposal to grant independent practice to Physician Assistants (PAs), as recommended by Mark Cushing, JD. I can only assume the Mr. Cushing will somehow gain financially from his proposal, as he does not practice medicine himself and has no medical training. I do hope his motivations are made transparent in this process and are critically evaluated.

Physician Assistant Education Inequality with Physician Education:
I have worked with Physician Assistants as part of my practice for over 10 years. They serve an important role on our team, and I value their educational model. However, they should not be working without extensive on-the-job training and oversight by a supervising physician.

One simply cannot possibly learn the breadth and depth of knowledge needed to practice medicine independently after completing a 27 month program, which is the length of training a PA receives.

Post-graduate medical education: 27 months for a PA vs 7-14 years for an MD/DO. (I omitted undergraduate years for both groups, as undergraduate programs are not “medical” training.) It is absolutely impossible that anyone with 27 months of education in any field can be equivalent to anyone with 7-14 years of education in that same field.

There is already a pathway to provide a Physician Assistant with independent practice and a doctorate, and it is called medical school.

AMA and State Medical Associations Do Not Support Independent Practice for Physician Assistants: The American Medical Association does not support the independent practice of physician assistants (http://www.acepnow.com/article/ama-president-dr-steven-stack-talks-physician-shortages-and-apps/). In addition, there are no state medical associations that support independent practice for Physician Assistants.

Physician Assistants Do Not Practice in Rural/Underserved Areas: The motivation for many legislators to support independent practice for PAs is because they expect PAs to fill a need in rural and/or underserved areas.

However, American Association of Physician Assistants (AAPA) data demonstrates that the vast majority of PAs practice in urban areas, so they are not a solution to a perceived lack of access in those areas (see attached).

The Solution is More Physicians: Instead of lowering standards for the independent practice of medicine, please consider these options:

• Working to increase the number of residency positions available to graduating medical students: In 2017, 8,640 graduating medical students found no residency position available to them. That’s nearly 8700 physicians who won’t be practicing medicine anywhere, despite their lengthy education.
Increase incentives for practicing in rural/underserved areas: Physicians graduate with staggering student loan burdens. Finding solutions that help alleviate that burden and increase the number of physicians practicing in rural/underserved areas is critical.

We all have the same goals: patient safety and access to excellent care.

Dr. Micaela Wexler, Clinical Assistant Professor, Kansas University Medical Center

56. I am writing to voice my firm opposition to the future proposal of allowing independent medical practice rights to Doctors of Medical Science.

I am a physician. I completed undergraduate studies, obtained a medical degree, as well as an internship and a three-year residency in Internal Medicine for a total of 13 years of post-high school education. During my medical training and residency, I logged well over 20,000 hours of clinical training and research.

Compare this to a physician assistant and nurse practitioner. By comparison, a nurse practitioner has approximately six to eight years of post-high school education. Their clinical education hours amount to approximately 1000 to 1500. A physician assistant has approximately six to six and a half years of post-high school education. They amount to approximately 2000 hours of clinical education. This is at the Masters level.

According to the Lincoln Memorial University Debusk College of Osteopathic Medicine, at which Mr. Moran and Mr. Cushing are faculty, adding the Doctor of Medical Sciences degree (which can be completed completely online according to the announcement on their web site) will add 50 credit hours and no clinical education hours, keeping the clinical education hours at approximately 2000 for the entire educational course.

Please keep in mind that we are currently dealing with the fall-out from Nurse practitioners who lobbied for independent practice in many states. Patients have suffered as a result of this due to the mistakes they make when their medical knowledge is simply lacking. There have been several horror stories which. I am able to provide examples if you need them.

With this in mind, there is just no way this on-line program with an additional 50 online credit hours can be sufficient to provide the necessary training needed to practice independently as a primary care provider. It is just not possible. As mentioned above, a primary care physician has about 20,000 clinical hours.

Also keep in mind that states that have independent practice for nurse practitioners have not demonstrated any increased access to primary care in Rural areas. Therefore, one can safely assume that creating this degree will not increase access to primary care.

In addition, the "Doctor of medical science" degree will only cause more confusion for patients who will not know the difference between this and a medical degree. This will open the door for the misleading of patients. Creating this program is just not in in the best interest of patients.

Providing Primary Care with under trained providers, and giving them full Medical Practice rights, as is suggested by this hearing, is just not in the best interest of Washingtonians and the USA as a whole.

I strongly urge you to vote against this proposal allowing full Medical Practice rights to Doctors of Medical Science. It is dangerous for Washingtonians and dangerous for the USA as a whole.
57. I am writing in opposition to the proposal to grant independent practice to Physician Assistants (PAs), as recommended by Mark Cushing, JD.

While PAs serve an important role on any healthcare team, however, they should not be working without on-the-job training and supervision by a physician (MD/DO).

Post-graduate medical education: 27 months for a PA vs 7-14 years for an MD/DO. As you can see the significant differences in education which equates to significant differences in depth of knowledge and clinical experience.

The American Medical Association does not support the independent practice of physician assistants (http://www.acepnow.com/article/ama-president-dr-steven-stack-talks-physician-shortages-and-apps/). In addition, there are no state medical associations that support independent practice for Physician Assistants.

Physician Assistants Do Not Practice in Rural/Underserved Areas. The American Association of Physician Assistants (AAPA) data demonstrates that the vast majority of PAs practice in urban areas, so they are not a solution.

The Solution is More Physicians:
Instead of lowering standards for the independent practice of medicine, please consider these options:
• Working to increase the number of residency positions available to graduating medical students: In 2017, 8,640 graduating medical students found no residency position available to them. That’s nearly 8700 physicians who won’t be practicing medicine anywhere, despite their lengthy education.
• Increase incentives for practicing in rural/underserved areas: Physicians graduate with staggering student loan burdens. Finding solutions that help alleviate that burden and increase the number of physicians practicing in rural/underserved areas is critical.

We can agree that patient safety and access to excellent care is the goal.

Thuy Hong Nguyen, MD

58. I am writing to express my concern for the bill allowing PAs to function independently. I am an emergency medicine physician and have had the privilege of supervising PAs. I think they are an essential part of the healthcare team.

However, to compare their 2-3 years of medical training to the at least 7 years of training that MD/DOs have is ludacris. It cannot be compared. Doctors straight out of medical school with 4 years of medical school have more training than PAs but we do not let them practice independently. There is a reason for that. Residency, which is at least 3 years of clinical training, academics, and research has no equivalent for NPs or PAs.

Please advocate for and protect our patients. Healthcare is teamwork and physicians are the ones with the training and knowledge to safely lead the team. Continue to fight for more residency positions to help with the physician shortage instead of replacing them with healthcare providers with less academic and clinical training.

Melanie B. Gates, MD, Emergency Medicine Physician, Capt, USAF, MC

59. I am writing to oppose the doctorate in medical science for physician assistants. As a MD, it appalls me that propositions like this are even considered. The standard for the practice of medicine in this
country is medical school followed by residency. For that there is no substitute. Groups may claim they are equivalent to us, but they are not. If you do decide to pass this, then I would ask one thing, make the physician assistants take the same board certification exams that we have to. It is not enough to claim that you are the same, you must prove it. Until then, you are providing unproven, substandard care. That is not what your constituents deserve.

Sunavo Dasgupta MD, Interventional Pain Management, Founder/Managing Partner, Premier Pain Specialists, Fellow, American Board of Anesthesiology

60. I have been trained as a Physician Assistant and later as a physician. I have trained PAs and thousands of medical students (MD and DO). I have a better understanding than most medical people about the difference in training between the professions. With that understanding, I would encourage you to move against the statute allowing independent practice by PAs. (AndNPs). This is from my experience as a PA, physician, and a medical educator. We hear about the desire to offer world class medical care to our citizens, this move is counterproductive. Don't do it!

Kevin Ragosta D. O.

61. I am writing to voice my concern over and opposition to the proposal to grant independent practice to Physician Assistants (PAs) as recommended by Mark Cushing, MD.

While they are a valuable part of a healthcare TEAM, PAs do not have the breadth or depth of training for independent practice. Their entire training is predicated upon the fact that they will always be working WITH a physician. As a Family Medicine Physician I have the opportunity to work with several PAs and understand the contributions they can make when appropriately supervised.

Ann Lee, DO

62. I am writing to voice my concern and opposition to the proposal to grant independent practice to Physician Assistants (PAs), as recommended by Mark Cushing, JD. I can only assume the Mr. Cushing will somehow gain financially from his proposal, as he does not practice medicine himself and has no medical training. I do hope his motivations are made transparent in this process and are critically evaluated.

Physician Assistant Education Inequality with Physician Education:

I have worked with Physician Assistants as part of my practice for over 10 years. They serve an important role on our team, and I value their educational model. However, they should not be working without extensive on-the-job training and oversight by a supervising physician.

One simply cannot possibly learn the breadth and depth of knowledge needed to practice medicine independently after completing a 27 month program, which is the length of training a PA receives.

Post-graduate medical education: 27 months for a PA vs 7-14 years for an MD/DO. (I omitted undergraduate years for both groups, as undergraduate programs are not “medical” training.) It is absolutely impossible that anyone with 27 months of education in any field can be equivalent to anyone with 7-14 years of education in that same field.

There is already a pathway to provide a Physician Assistant with independent practice and a doctorate, and it is called medical school.

AMA and State Medical Associations Do Not Support Independent Practice for Physician Assistants:
The American Medical Association does not support the independent practice of physician assistants (http://www.acepnw.com/article/ama-president-dr-steven-stack-talks-physician-shortages-and-apps/). In addition, there are no state medical associations that support independent practice for Physician Assistants.

Physician Assistants Do Not Practice in Rural/Underserved Areas:

The motivation for many legislators to support independent practice for PAs is because they expect PAs to fill a need in rural and/or underserved areas.

However, American Association of Physician Assistants (AAPA) data demonstrates that the vast majority of PAs practice in urban areas, so they are not a solution to a perceived lack of access in those areas (see attached).

The Solution is More Physicians:

Instead of lowering standards for the independent practice of medicine, please consider these options:

- Working to increase the number of residency positions available to graduating medical students: In 2017, 8,640 graduating medical students found no residency position available to them. That’s nearly 8700 physicians who won’t be practicing medicine anywhere, despite their lengthy education.

Increase incentives for practicing in rural/underserved areas: Physicians graduate with staggering student loan burdens. Finding solutions that help alleviate that burden and increase the number of physicians practicing in rural/underserved areas is critical.

We all have the same goals: patient safety and access to excellent care.

Neha G Narula

63. I have reviewed some of the responses to the follow-up questions, but had to stop as they are blatant untruths. This applicant has tried passing the same legislation in TN, despite his having no interest in the field, other than financial. We plan on having multiple physicians there to counter his (often false) arguments.

Noah Gudel

64. There just isn't enough time or space to go into all the reasons why independent practice for mid-level practitioners is a bad idea. Suffice it to say, there are no shortcuts to quality healthcare. Medical illness and the human body is just to vastly complex to allow for abbreviated training programs, and then for the public to be used as fodder for their incompetence.

I have had daily contact with mid-level practitioners for well over a decade. What I see daily is frightening, compounded by the possibility that their poor decisions would go unchecked in independent practice.

The only rationale for their approval would be that substandard care that it's acceptable for certain portion of our population.

Avoid the 'quick fix' that is no fix. Please, fund more residencies, open more medical schools, but do not accept exposing the general public to the real dangers of independent mid-level practice.
65. I am writing to voice my deep concern and very strong opposition to the proposal to grant independent practice to Physician Assistants (PAs), as recommended by Mark Cushing, JD. I can only assume the Mr. Cushing will somehow gain financially from his proposal, as he does not practice medicine himself and has no medical training. I do hope his motivations are made transparent in this process and are critically evaluated.

I am very strongly opposed for the following reasons:

1) Physician Assistant Education Inequality with Physician Education:

Many of my colleges have worked with Physician Assistants as part of their practices for many years. They serve an important role on our team, and I value their educational model. However, they should not be working without extensive on-the-job training and oversight by a supervising physician.

One simply cannot possibly learn the breadth and depth of knowledge needed to practice medicine independently after completing a 27 month program, which is the length of training a PA receives.

Post-graduate medical education: 27 months for a PA vs 7-14 years for an MD/DO. (I omitted undergraduate years for both groups, as undergraduate programs are not “medical” training.) It is absolutely impossible that anyone with 27 months of education in any field can be equivalent to anyone with 7-14 years of education in that same field, especially when you add the fact that residency training is 60-80 hrs a week, thus making 3-7 years of residency the time (NOT content) equivalent of 4.5-14 years of PA work.

There is already a pathway to provide a Physician Assistant with independent practice and a doctorate, and it is called medical school.

2) AMA and State Medical Associations Do Not Support Independent Practice for Physician Assistants:

The American Medical Association does not support the independent practice of physician assistants. (http://www.acepnow.com/article/ama-president-dr-steven-stack-talks-physician-shortages-and-apps/). In addition, there are no state medical associations that support independent practice for Physician Assistants.

3) Physician Assistants Do Not Practice in Rural/Underserved Areas:

The motivation for many legislators to support independent practice for PAs is because they expect PAs to fill a need in rural and/or underserved areas.

However, American Association of Physician Assistants (AAPA) data demonstrates that the vast majority of PAs practice in urban areas, so they are not a solution to a perceived lack of access in those areas (see attached).

4) The Solution is More Physicians:

Instead of lowering standards for the independent practice of medicine, please consider these options:

• Working to increase the number of residency positions available to graduating medical students: In 2017, 8,640 graduating medical students found no residency position available to them. That’s nearly 8700 physicians who won’t be practicing medicine anywhere, despite their lengthy education.
• Increase incentives for practicing in rural/underserved areas: Physicians graduate with staggering student loan burdens. Finding solutions that help alleviate that burden and increase the number of physicians practicing in rural/underserved areas is critical.

We all have the same goals: patient safety and access to excellent care. Independent practice for PAs work absolutely counter to both of these. Patients are at huge risk without even being aware of their practitioner's dramatic lack of experience compared to a physician. I am particularly concerned with this proposal because my sister, her husband, and their 3 children are Washington residents and may be put at risk because of it.

Amy Cecilia Mogal, MD/PhD

66. The differences in training, education, and drive (made exemplary by great sacrifice) is profound when comparing Physicians (MDs and DOs) to any mid-level provider such as Physician-ASSISTANTS and Nurses (whether or not they have lobbied for independent practice). If you or your family member contracted a disease - any disease, would you rather see a medical doctor who has extensive training, experience, and importantly the critical thinking skills to diagnose and treat you, or would you rather have a mid-level provider without those traits who’s only experience is following the orders and decisions made by a Doctor? In the era of patient safety, we should not lower the standard of care to those with less training, experience, and skill. Please do not sacrifice the safety of patients in Washington to appease a lobbying group. Bad care is not an answer to poor access to good care. There are other ways!

Eric R Anderson MD, PhD, Intensive Neuro

67. Please oppose independent practice for physician assistants. They are trained to assist physicians, not replace them. It is in their title. They do not have adequate training or oversight to provide safe care independently.

Thank you for your time.

Dr. Alisha King

68. I am writing to voice my firm opposition to the future proposal of allowing independent medical practice rights to Doctors of Medical Science.

I am a physician. I completed undergraduate studies, obtained a medical degree, as well as a four-year residency in Internal Medicine and Pediatrics for a total of 13 years of post-high school education. During my medical training and residency, I logged well over 20,000 hours of clinical training and research.

Compare this to a physician assistant and nurse practitioner. By comparison, a nurse practitioner has approximately six to eight years of post-high school education. Their clinical education hours amount to approximately 1000 to 1500. A physician assistant has approximately six to six and a half years of post-high school education. They amount to approximately 2000 hours of clinical education. This is at the Masters level.

According to the Lincoln Memorial University Debusk College of Osteopathic Medicine, at which Mr. Moran and Mr. Cushing are faculty, adding the Doctor of Medical Sciences degree (which can be completed completely online according to the announcement on their web site) will add 50 credit
hours and no clinical education hours, keeping the clinical education hours at approximately 2000 for the entire educational course.

Please keep in mind that we are currently dealing with the fall-out from Nurse practitioners who lobbied for independent practice in many states. Patients have suffered as a result of this due to the mistakes they make when their medical knowledge is simply lacking (there are documented cases to back this up if you would like examples).

With this in mind, there is just no way this on-line program with an additional 50 ONLINE credit hours can be sufficient to provide the necessary training needed to practice independently as a primary care provider. It is just not possible. As mentioned above, a primary care physician has about 20,000 clinical hours in addition to classroom instruction and research.

Also please keep in mind that states that have independent practice for nurse practitioners have not demonstrated any increased access to primary care in Rural or underserved areas. Therefore, one can safely assume that creating this degree will not increase access to primary care.

In addition, the "Doctor of medical science" degree will only cause more confusion for patients who will not know the difference between this and a medical degree. This will open the door for misleading patients. Creating this program is in no way in the best interest of patients.

Providing Primary Care with under trained providers, and giving them full Medical Practice rights, as is suggested by this hearing, is not in the best interest of Washingtonians or the USA as a whole.

I strongly urge you to vote against this proposal allowing full Medical Practice rights to Doctors of Medical Science. It is dangerous for Washingtonians and dangerous for the USA as a whole.

Daina M. Roberson, MD

69. I am writing to voice my FIRM opposition to the future proposal of allowing independent medical practice rights to Physician's Assistants via a Doctors of Medical Science program.

I am a Primary Care Physician and have been in practice for 19 years. Prior to practicing, I completed undergraduate studies, medical school and three years of residency training in Family Medicine. This is 12 years of post high school education.

Comparing my education and training to that of a physician assistant or nurse practitioner results in a deficit of 4-6 years. Clinical training hours for mid-level providers range from 1000-2000 versus my 15,000+ clinical hours as a medical doctor. They are simply not equivalent nor their training adequate to practice on their own.

Physician assistants work well in conjunction with physicians and are a valuable contributors to the team. They are trained to assist physician's and not practice medicine independently. PA's also do not fill much needed vacancies in rural medicine and studies have shown they largely practice in urban and suburban environments.

This year, over 8000 physicians did not match with residency training programs, largely due to deficient in available positions. Efforts to create more residency positions to allow more practicing physicians into our profession would be more fruitful than this Doctors of Medical Science program.

Please help us maintain the integrity of our medical degrees and professions. I appreciate your consideration in this matter and again reiterate my grave concern for approval of this program.
Jennifer S. Kay, M.D., Board Certified Family Physician

70. I am writing to voice my concern and opposition to the proposal to grant independent practice to Physician Assistants (PAs), as recommended by Mark Cushing, JD.

While a shortage of primary care physicians is an ongoing issue in this country, instead of trying to fix the problem by training more PHYSICIANS and opening more residency positions, our policy makers continue to look for lower quality replacements. This is extremely unfair to the general public and our rural community. They deserve better. I understand that residency funding comes from CMS. So here is an idea - increase the funding and make cuts somewhere else.

Physician ASSISTANTS are just what their name suggests. ASSISTANTS to physicians. They provide a valuable part in patient care in essentially acting as Physician extenders. Their curriculum is designed to assist, not to be making decisions.

I would like to highlight some of the differences in our training. In your FAQ's, there is a gross misrepresentation of PA training. It mentions that PA's do 4 semesters of didactics and 1 clinical year, when in reality it is only 2 full semesters and 1 summer (6 week semester) of didactics. I also want to mention that the curriculum for this DMS degree is based on MKSAP. I want to point out that Medical Knowledge Self Assessment Program is a REVIEW PROGRAM. It is by no means a stand alone guide for our knowledge gained during residency training. If someone is trained solely by review books, there is obviously going to be a huge knowledge gap. To think that this would prepare them enough to practice medicine independently is a joke.

I would like to also address the part about "experience" that is thrown around very loosely when debates regarding this comes up both with NP independence, and now this. According to the FAQ's, the PA's are required to have 3 years of experience before enrolling into this program. While this experience is wonderful for a trainee to excel in their field, it does not make them physicians. The experience they are gaining is how to be a physician ASSISTANT. NOT to make decisions and making diagnoses. So in essence, this experience does not count.

Physicians in primary care do at least 4 years of medical school, followed by a 3-year residency training, which is geared towards making them learn how to make decisions. You are working 80 hour weeks, which I beg you not to equate to the 40 year weeks that PA's do with weekends and holidays off. If physician assistants wanted to act as physicians, why did they not go to medical school? That option is always open to them.

I feel appalled by the fact that I have to point out these differences to anyone. It is like asking an accountant why s/he is better than his/her secretary. And we are talking about people's lives here.

I have 2 questions for you:

- Would you like a flight attendant fly your airplane after s/he has had "experience" for 3 years?

- Would you like your family members or you yourself to be treated by a Physician or a Physician Assistant?

I believe our rural community deserves better. You know the distribution of funds needs to be addressed but clearly, the quality of care is the last thing on you guys' minds. You are playing with people's health and it is highly irresponsible and inhumane to be going this route.

Dr. Umama Adil MD
71. I am writing to voice my deep concern and very strong opposition to the proposal to grant independent practice to Physician Assistants (PAs), as recommended by Mark Cushing, JD. I can only assume the Mr. Cushing will somehow gain financially from his proposal, as he does not practice medicine himself and has no medical training. I do hope his motivations are made transparent in this process and are critically evaluated.

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2) Post-graduate medical education: 27 months for a PA vs 7-14 years for an MD/DO. (I omitted undergraduate years for both groups, as undergraduate programs are not “medical” training.) It is absolutely impossible that anyone with 27 months of education in any field can be equivalent to anyone with 7-14 years of education in that same field, especially when you add the fact that residency training is 60-80 hrs a week, thus making 3-7 years of residency the time (NOT content) equivalent of 4.5-14 years of PA work.

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However, American Association of Physician Assistants (AAPA) data demonstrates that the vast majority of PAs practice in urban areas, so they are not a solution to a perceived lack of access in those areas (see attached).

5) The Solution is More Physicians:

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We all have the same goals: patient safety and access to excellent care. Independent practice for PAs works absolutely counter to both of these. Patients are at huge risk without even being aware of their practitioner's dramatic lack of experience compared to a physician. I am particularly concerned with this proposal because my sister, her husband, and their 3 children are Washington residents and may be put at risk because of it.

Katherine Barton, MD

72. I write to vehemently oppose independent practice of physician ASSISTANTS because their training is designed to have them ASSIST an extensively trained physician and not to actually be one. As a medical doctor (MD) and board certified psychiatrist, I have been astounded by the medical error rate of mid-level practitioners to the point that I refuse to see them for my own care and also advise my friends and family to do the same. I liken it to the training of a pilot - would you rather be in a plane flown by Pilot A: years of well designed and extensive training and experience or Pilot B: who took a couple classes and observed a couple of flights? If you wouldn't put your family on a plane flown by Pilot B then don't allow physician Assistants independent practice. Or think about this very moment when your mother or your son has a treatable cancer missed by someone without the expertise or experience to appropriately diagnose and treat it.

Elizabeth Chmelik MD

73. I oppose independent practice of physicians assistants because they are not physicians (2 years of education vs 7+). If they want to be doctors, they should go to medical school for appropriate training and experience to take on this important job. Lives are at stake here.

Ethan Owens

74. I am writing to express my opposition to the sunrise proposal for a Doctor of Medical Sciences which would grant physician assistants independent clinical practice which would be equivalent to that of a medical doctor.

As a Family Medicine physician who completed medical school at a university which also includes a physician assistant program I have an intimate understanding of their education. These students rotated along side of us medical students on core rotations during our clinical experience. The difference is, they had spent less time on didactic, book work education prior to these experiences and it often showed in their lack of knowledge of the physiology of disease. They also had a much shorter requirement for clinical rotations, just one year compared to our two. The time that was not spent on rotation with us was often spent on elective observerships while our extra year was spent on required, detailed rotations that we needed to perform well on to secure a residency position.

Which brings me to the next, most glaring, difference in our education. While the PA students graduated a year to a year and a half sooner than we did, us medical students went on to a residency which lasts anywhere from 3-7 years depending on specialty (and before fellowship for those who become sub-specialists) and is required for board certification. During this time we are honing our skills in our chosen specialty under the strict supervision of experienced physicians. We must discuss EVERY patient (not just a certain percentage) with the attending physician, and nearly always the patient is also seen by that physician. This time is crucial for physicians to become safe independent practitioners. By granting this independence to those with less education and less training, patients will be put at risk. In addition, Family Medicine is the front lines of health care and must have the widest base of knowledge to appropriately treat patients. It is not the place for under-trained practitioners to
be let loose on their own. The team-based model was developed for a reason, and it increases access to care while remaining safe for patients.

Please consider this important difference in training before allowing independent practice by anyone other than a trained physician.

Calin Kirk, MD

75. I am a practicing Nephrologist in Seattle, WA. I am also boarded in Internal Medicine.

I am a practicing Nephrologist in Seattle, WA. I am also boarded in Internal Medicine.

Calin Kirk, MD

I am writing to voice my concern and opposition to the proposal to grant independent practice to Physician Assistants (PAs), as recommended by Mark Cushing, JD.

I have worked with and value the role of Physician Assistants as part of a medical team lead by physicians. However, to grant independent practice to physician assistants would be a disservice to the residents of our state who deserve health care by the most qualified person with the highest level of training. That person is someone who has completed 4 years of medical school, passed steps 1, 2, and 3 of Medical boards, completed 3-7 years of residency involving supervised practice and potentially several more years of fellowship, and passed a board exam in their specific area of training to earn the title and honor of being a physician fully qualified to practice in their field of expertise.

Physician assistants do not undergo nearly the amount nor rigor of training as a physician. As technology continues to advance, one simply cannot practice safely unsupervised while only learning the very basic and superficial aspects of medicine. There is only so much a physician assistant can learn and do and see in a 27 month program, then be ready to practice without supervision. While some people feel that primary care is "easy" no one can predict when a simple cough, cold, or fever is a sign of something more sinister without having the breadth of knowledge and experience that is required of a physician.

The solution to fulfilling the "shortage" of primary care physicians is not to shortcut education and training by allowing less qualified providers fill in the gaps. Medical school positions have increased in the last 10 years, while residency positions have not. Completing a residency program is needed after medical school for a physician to safely and legally practice medicine.

Instead of lowering standards for the independent practice of medicine, please consider these options:

• Working to increase the number of residency positions available to graduating medical students: In 2017, 8,640 graduating medical students found no residency position available to them. That’s nearly 8700 physicians who won’t be practicing medicine anywhere, despite their lengthy education.

• Increase incentives for practicing in rural/underserved areas: Physicians graduate with staggering student loan burdens. Finding solutions that help alleviate that burden and increase the number of physicians practicing in rural/underserved areas is critical.

We all have the same goals: patient safety and access to excellent care. Please do not allow this proposal to pass.

Alice M. Chang, MD

76. I am a physician licensed in Washington state. I have worked with many physician assistants, and while they are valuable team members, they do not have adequate training to practice medicine independently. A short training program that gives them the term "doctor" in a Doctor of Medical Science degree is confusing to patients who may think they are seeing a fully trained, certified, and
licensed physician. Legislating equality is foolish. There are many PAs who have gone on to attend medical school and that should be the only pathway from PA to independent practice.

Caroline Roberts, MD

77. I am writing to voice my concern and opposition to the proposal to grant independent practice to Physician Assistants (PAs), as recommended by Mark Cushing, JD. As a physician who works with physician assistants, I am acutely aware or the difference in training and medical knowledge and how this will hurt patients.

Physician Assistants serve an important role on our team, and I value their educational model. However, they should not be working without extensive on-the-job training and oversight by a supervising physician.

One simply cannot possibly learn the breadth and depth of knowledge needed to practice medicine independently after completing a 27 month program, which is the length of training a PA receives.

Post-graduate medical education: 27 months for a PA vs 7-14 years for an MD/DO. It is absolutely impossible that anyone with 27 months of education in any field can be equivalent to anyone with 7-14 years of education in that same field.

The pathway to provide a Physician Assistant with independent practice and a doctorate, should continue to be thru medical school and not thru misguided legislation.

The American Medical Association does not support the independent practice of physician assistants (http://www.acepnw.com/article/ama-president-dr-steven-stack-talks-physician-shortages-and-apps/). In addition, there are no state medical associations that support independent practice for Physician Assistants.

Some feel this type of legislation will fill needs in underserved or rural areas. However, American Association of Physician Assistants (AAPA) data demonstrates that the vast majority of PAs practice in urban areas, so they are not a solution to a perceived lack of access in those areas.

Instead of lowering standards for the independent practice of medicine, please consider these options:
• Working to increase the number of residency positions available to graduating medical students: In 2017, 8,640 graduating medical students found no residency position available to them. That’s nearly 8700 physicians who won’t be practicing medicine anywhere, despite their lengthy education.
• Increase incentives for practicing in rural/underserved areas: Physicians graduate with staggering student loan burdens. Finding solutions that help alleviate that burden and increase the number of physicians practicing in rural/underserved areas is critical.

We all have the same goals: patient safety and access to excellent care. This proposed legislation does not meet those goals.

Katherine Parenti MD

78. I know I am not a resident of your state, but I feel I must speak up against the consideration of allowing physician assistants to practice independently. I am not against mid level providers. They do have a place in our healthcare system, however, this place should be under the close supervision of a physician. Through the last ten years, I have employed eight mid level providers in my Internal Medicine/Pediatrics private practice, one or two at a time. I have also worked with the local nurse practitioner program at USD to help train. In this same time, I have been a preceptor for UCSD
medical students as well as residents in the Internal Medicine/Pediatrics program. I can tell you there is a world of difference between mid level providers and physicians. Even at the training level, my MD residents were much more knowledgeable than the experienced mid levels I paid to work in my practice. In my office, the mid levels see the simple cases, often still discussing these with me. They have provided increased patient access in my office, for which I am grateful, but I can't imagine any of them practicing autonomously. I honestly hate to admit this, but I have seen many instances where my midlevel providers have likely increased costs for patients through unnecessary testing and referrals. I sometimes find myself backtracking for them, often making follow-up phone calls or visits to revisit issues. I would prefer to hire an MD, but one suitable for my practice mix is difficult to find.

Again, while midlevels do help alleviate some congestion in the system, allowing them to practice autonomously is likely to only increase the costs in the system and is a disservice to our patients.

Laura Norton Petrovich, M.D, Coronado, CA

79. As a physician in the neighboring state of Idaho, I am writing to provide my strong disagreement with the proposal to license and regulate Physician Assistants who have completed the Doctor of Medical Science Degree (DMS).

The DMS degree has been newly created and the quality of the program and its graduates remain untested. They like to make the claim that this will make graduates equivalent to a medical doctor who has completed 4 years of medical school and at least three years of strenuous and regulated residency training. This is simply an untrue claim. Although entrance into the program requires 3 years of work after PA school there is no possibility that three years of work would be anywhere near equivalent to a residency in internal medicine, family medicine, or pediatrics. The DMS program can be completed online which is never going to match the demands of hospital and clinic based training.

I ask who you want to care for you in your time of need? Who would you like by your side to guide your loved ones though a complicated or life-threatening diagnosis? A physician who has completed a highly regulated and standards based curriculum for 4 years and 3 years of demanding practice with constant supervision; or a PA who handled easy diagnoses in a community clinic and decided to take some online courses?

If I can be of further service please feel free to contact me.

Dustin Portela, DO, Dermatologist & Mohs Surgeon

80. I have read the proposal materials and strongly oppose the creation of this short cut to becoming a Physician. Simply using online computer instruction does not make a PA equal to a trained MD or DO. It takes thousands of hours of actual patient care in acute settings such as a hospital based training complex to even begin a Physician on the path to safe practice of primary care medicine. The training Physician has to also pass several rigorous national exams which cannot be failed or the year of training has to be repeated. At the end , a primary care Physician has to be able to independently recognize and treat or refer correctly to a specialist , over 400 major illnesses . This has to be done in a matter of minutes while seeing patients, without relying on a back up physician constantly present to catch mistakes. I have reviewed the courses for this DMS degree and they are only a fraction of what is required to even graduate from a US allopathic medical school. Allowing a PA with just 2 years of remote education to practice on ill people independently is a disaster that will present itself in court for malpractice.

The basis for my comments is derived from my MD degree from a US school of Medicine, training at a US University level medical center, subsequent /continual Board certifications and full time practice in primary care Internal Medicine since 1993; since 1997 I have practiced in WA full
time. I have patients who have sought my care after leaving a PA's service. My review of their notes is akin to reading a medical student's second year essay on illness and therapy; it is weak and shows a struggle with the basic concepts of human illness. Allowing a PA to become equal to a MD Physician and to be called a "doctor" will only decrease the quality of care for Washington citizens who thought there were getting a fully trained doctor but instead a substitute. It will lead to more cases of malpractice and loss of public confidence in medical care and the DOH itself.

Ken P. Lee MD

81. I am very concerned about NP's and PA's pushing for independent practice. This is not safe for patients, including your family, my family and everyone.

I was an RN before I went to medical school. The difference between nursing education and medical education cannot be over emphasized. Midlevels do not have the years of experience in residency where you are mentored by attendings for years and taught the science and art of medicine. There is also a level of responsibility that you obtain as a resident physician which we take to heart and learn how important knowing your medicine is. A life will depend on it.

While PA's and NP's play roles in the healthcare team that are important, they cannot be allowed to practice medicine by diagnosing and prescribing without supervision.

NP's started out denying they wanted independent practice and now they and PA's are both trying to become independent. PA's are afraid they will be passed over for jobs if NP's do not require supervision but they do. Corporate medicine is all bout th ebottom line.

This is not about jobs. This is about safe health care.

There is a shortage of primary care physicians. We need more well trained physicians, not more midlevels pretending to be physicians.

Cheryl Ferguson MD

82. I am writing to oppose independent practice of physician ASSISTANTS. I am a board certified Anesthesiologist and I strongly urge you to stop this madness. Physicians are highly trained and spend years in training to perfect their skills. The training and maintenance of certification is paralleled by no other profession. A PA does not have anything near the same education and time in training is not the same between the two professions. PA often get done at 3 pm in training while physician live in the hospital doing an actual residency. pA do not know what they do not know because they simply can not learn everything in their brief and subpar training. If they want independence please encourage them to go to medical school instead. I ask you when your child is ill do you want a physician or someone with 1/4 th the training making life and death decisions for them?

Patients, you, your family deserve the best care when ill. Delays in diagnosis due to inadequate fund of knowledge (secondary to a quarter of training) can be deadly.

Hb 1771 no to Physician ASSISTANTS independent practice. They are trained as assistants from the start even their name implies this. They should never be practicing without supervision.

Ali Morrell-Balanon, MD
83. I am opposed to Hb 1771 giving independence to mid-level providers. I am a practicing physician and I see so many mistakes. They are good as mid-level providers and following under a physician but are not capable of practicing independently.

I had a patient on Tuesday whose nurse practitioner adjusted her medications and caused her to have CNS depression. The patient was very foggy, couldn't remember things and was very depressed. A physician would not do that! It was the simple act of just checking their medications which was not done by the Nurse practitioner

Please think about the patients. Would you want to be flown to another country by the flight attendant or the pilot? That is essentially what you were saying if you give independence to mid-level providers because they do not have the education or training to be fully independent.

If you do not wish it on yourself, do not force it on your constituents

Neha Bhanusali MD

84. I am a Family Physician who is writing to express my opposition to HB-1771, allowing independent practice of PAs. The expansion of PA scope of practice without physician oversight is a danger to patients. To be clear, PA's are a valuable member of the health care team, a team that must always be physician led. They are, by name, a physician assistant.

The education and training of physicians and PAs are incomparable. Physician education encompasses four years of college, four years of medical school with two in the classroom and two full-time clinical. Medical school is followed by a minimum of three years post graduate clinical training. Physicians take three steps of a very sophisticated licensure exam (USMLE), encompassing basic science and clinical knowledge. After years of residency, physicians take another exam for board certification. The physicians' required post graduate (residency) training averages eighty hours a week of work. It is a rigorous and standardized pathway.

The pathway to become an PA is much shorter, less rigorous, and educational programs are not standardized. The breadth of knowledge of graduating and experienced PAs is insufficient to independently manage patients without physician oversight. Again, I want to emphasize that there are many excellent PAs in practice, who play an important role in the health care team, but should not function independently.

One of the arguments for expanding scope of PA practice is that there is a physician shortage. However, expansion of PA scope of practice has not led to more access to care in underserved areas. Studies show that most PAs work in the same areas as physicians. And truly, I believe that patients in more rural and underserved areas deserve the same high quality standard as all other patients. The states that have granted independent practice to PAs have not seen an increase of PAs moving to rural areas to increase access.

Again, I strongly urge you to oppose physician assistant independent practice HB-1771 for the SAFETY of our patients.

Avani Rana Gupta D.O., M.S., Diplomat, Family Medicine
Western University COMP Medical School

85. I write to strongly discourage the HB 1771 which would jeopardize patients by allowing physicians assistants to practice independently in primary care. Primary care is the linchpin of health care in this
country. Physicians complete medical school and then residency training in family medicine, internal medicine obstetrics or pediatrics, acquiring thousands of hours of clinical acumen. The contrast with physician assistants is not only stunning, but dangerous; a PA’s two year study provides operational understanding but not diagnostic capacity.

I have practiced 10 years as an anesthesiologist in a Level 1 tertiary center covering obstetric, trauma, burn, cardiac, pediatric and transplant care and I have learned a hard truth: patients survive complex illness because of primary physician care. These physicians recognize, diagnose and manage recovery. In my medical career, the massive influx of other providers like physician assistants has provided many extra hands to manage a burgeoning health care need, but these assistants are not physician equivalents.

Do not allow legislative lobbying to supplant what physicians assistants failed to acquire, a demanding and intense medical school education followed by a validated residency training program.

Amanda Brown MD

86. I am opposed to Hb 1771 giving independence to mid-level providers. I am a practicing physician and I see so many mistakes. They are good as mid-level providers and following under a physician but are not capable of practicing independently.

I had a patient on Friday whose mid-level missed obvious signs of sepsis and caused her to be admitted to the ICU in seriously deteriorating condition! A physician would not do that! It was the lack of training and expert judgment that only a trained physician has.

Please think about the patients. Would you want to be flown to another country by the flight attendant or the pilot? That is essentially what you were saying if you give independence to mid-level providers because they do not have the education or training to be fully independent.

If you do not wish it on yourself, do not force it on your constituents

ROMIL PATEL MD, THE VILLAGES, FL

87. I am a practicing physician in Washington, license WA 23639. I am 39 years out of medical school, University of California San Francisco 1978. I am residency and fellowship trained and board certified internal medicine and geriatric medicine. I am concerned about providing and sustaining quality health care.

I have reviewed the proposal to create a new category of medical professional. I AM AGAINST this proposal for the following reasons.

1. While there are inadequate primary care physician resources, especially in rural areas, there reasons for this are well known.
   A. Medical school debt discourages primary care over more lucrative earning potential of speciality care.
   B. Rural communities may not be able to provide challenging employment to physician spouses.
   C. Chronically inadequately staffed clinics and hospitals lead to turnover and burnout.
   I THINK THESE WELL KNOWN AND ESTABLISHED FORCES WOULD ALSO IMPACT ANY NEW PRIMARY PRACTITIONER!

2. We already have all the pieces of the puzzle with PA, NP, and primary care MD (Pediatrics, Family
Medicine, General Internal Medicine). What needs to happen is to better organize and strengthen these practitioners and incent and compensate them to combine their skill sets to provide primary care for our country. Many efforts, for example expansion of Family Medicine training programs, are underway.

Mary A. Shepard MD

88. I am writing to oppose the bill allowing the doctor of medical science degree to be given to physician assistants. There is already a pathway to provide a Physician Assistant with independent practice and a doctorate, and it is called medical school. The creation of a new degree will only serve to blur lines and confuse patients.

Physician Assistants do not practice in rural areas. American Association of Physician Assistants (AAPA) data demonstrates that the vast majority of PAs practice in urban areas, so they are not a solution to a perceived lack of access in those areas.

There has already been a growth in positions for medical school. There is now a surplus of medical school graduates who are ready to fill the nation's need for more care, but a lack of residency training positions. Creating a new degree is not the answer to this problem.

The Solution is More Physicians:
Instead of lowering standards for the independent practice of medicine, please consider these options:
• Working to increase the number of residency positions available to graduating medical students:
  In 2017, 8,640 graduating medical students found no residency position available to them. That’s nearly 8700 physicians who won’t be practicing medicine anywhere, despite their lengthy education.
• Increase incentives for practicing in rural/underserved areas: Physicians graduate with staggering student loan burdens. Finding solutions that help alleviate that burden and increase the number of physicians practicing in rural/underserved areas is critical.

We all have the same goals: patient safety and access to excellent care.

Caroline Halverstam, MD

89. My name is Dr Beth Warren, I’m an ER resident graduating in May and am writing to oppose the bill to allow PAs to get their doctorate and practice independently. I oppose independent practice for both NPs and PAs. In no way is a 1-2 year curriculum equivalent to 4 years of medical school followed by four years of residency. Some of our PAs are great but many come to frequently consult with the attending (appropriately), but some don't know what they don't know and are cocky and discharge inappropriately or order the wrong test or unnecessary tests. I was working with a PA who saw a young girl who had been in a car accident 24-36 hours prior going 80 mph when she hit the median and was not wearing a seatbelt. This NP or PA did not feel she needed a head CT or neck CT and only ordered xrays. When voting on this bill you need to ask yourself would you feel comfortable being seen by a PA or with your family being seen by a PA and never seen by an MD/DO? I was taught to treat all patients as if they were my family. I have had bad experiences with some PA appointments and now request to only see the doctor in the practice. I just heard about NPs being allowed to perform cardiac catheterizations unsupervised and it's unknown if patients are aware their procedure is not being performed by their doctor. I find this a very slippery slope. Mid levels need to stay within their scope of practice and be supervised by a physician.

Dr Beth Warren
90. During the 2015 legislative session of how to give PAs expedited access to an MD license, as I recall, the hurdle we ran into was ACGME residency requirements. I think we determined that the state couldn’t make modifications to those requirements. What if NCPAA could provide an exam similar to the USMLE Step 3, if a PA could pass that exam then they could be given the opportunity to sit for an unfilled US Family Residency position. We need to change residency requirements. Maybe family residency programs could even add on a Doctor of Medical Science residency position that might not interfere with ACGME requirements. This would reduce the cost from 50,000 dollars, to the cost of an examination. It would also allow the United States to build family medicine positions as many of our medical programs throughout the country are now training specialists and not family medicine doctors.

Many PA’s have been well trained and have come from, already, rigorous backgrounds. I think many PA’s are well equipped to take on the family doctor shortage in this country if you could just give us the okay at the launch pad. We need to get rid of some of the red tape. We could reduce the cost of training in this scenario and fill, unfilled family med residency positions. It is the residency option that is missing from PA training and I feel it is the residency training that will make us stronger clinicians, not a 2 year online program.

Please keep me posted on updates to the sunrise proposal.

Rachel Ragosta, PA-C, CAQ-Hospital Medicine, RN

91. I am writing in regards to the SB 850 (TN) /Doctor of Medical Science bill (WA) to express my strong opposition to the creation of a new profession which would allow physician assistants to be the “equivalent of physicians.” As an internal medicine physician who is affiliated with a nurse practitioner residency program and has many friends who are physician assistants, I am well-informed of the vast difference in training among physician assistants, nurse practitioners and medical doctors. I am concerned that the current Doctor of Medical Science degree is not rigorous enough to provide physician assistants with adequate training to practice as independent primary care providers. The Doctor of Medical Science degree consists of a 1 year online curriculum using a board review text followed by 1 year of supervised practice. This training is vastly different from a general internist, pediatrician or family medicine physician. I believe that only providers who have adequate training should practice medicine independently. There are other, more safe avenues to address the primary care shortage, rather than hiring providers who lack the medical knowledge and experience to safely treat more complicated primary care patients. PA independent practice, as currently proposed, is unacceptable. My fear is that primary care, which is one of the most complicated specialties, is being relegated to “just primary care.” I hope this bill does not pass and that you will stand up to protect patients. American citizens deserve more than subpar healthcare.

Jessica Deslauriers, MD

92. I am very opposed to physician assistants getting independent practicing allowance. This past weekend, instead of diagnosing kidney failure in my patient the mid level provider gave water pills to make the leg swelling go down.

This is horrible and the patient could have ended up on permanent dialysis. And instead of actually diagnosing, they made the situation worse. They gave water pills. And all they did during the visit was discuss her cholesterol which had nothing to do with anything (and actually was from kidney failure)

Unless you can truthfully say to yourself that you believe mid-level care is equal to physician care, don't do this to yourself, your family, your constituents.
There has been talk of secondary gain from your office in allowing this bill to pass. If a patient gets hurt because of inappropriate care due to greed, this will be public knowledge.

Please don't hurt another human being because of additional money in your pocket.

-A concerned physician

93. Allowing unsupervised NP’s to have a Doctor of Medical Sciences and work independently is a dangerous idea and a public health hazard. There has already been a cost on the public allowing them to have limited supervision. Patient’s diagnosis’ have been delayed or worse, missed altogether. People have already been hurt. To allow for such independence and unsupervised roles is, at best, negligent. Being in healthcare, it is easier to know the difference in quality of care but as the majority of the public has no idea, they are left getting hurt when they go for help. I would hope for the sake of our families, children, friends we have a better understanding of the differences in the quality of medical care to allow for this level of lack of supervision that has already been proven to hurt people.

Kiran Nuthi, M.D.

94. I am writing to voice my concern and opposition to the proposal to grant independent practice to Physician Assistants (PAs).

Physician Assistant Education Inequality with Physician Education:
I have worked with Physician Assistants as part of my general surgery training at the University of Washington (06/2007-06/2015). They served an important role on our teams, and I value their educational model. However, they should not be working without extensive on-the-job training and oversight by a supervising physician.

One simply cannot possibly learn the breadth and depth of knowledge needed to practice medicine independently after completing a 27-month program, which is the length of training a PA receives.

Post-graduate medical education: 27 months for a PA vs 7-14 years for an MD/DO. My personal training was over 9 years long, including subspecialty research at Seattle Children's Research Institute during my general surgery residency at the University of Washington. (I omitted undergraduate years for both groups, as undergraduate programs are not "medical" training.) It is absolutely impossible that anyone with 27 months of education in any field can be equivalent to anyone with 7-14 years of education in that same field.

There is already a pathway to provide a Physician Assistant with independent practice and a doctorate, and it is called medical school. Shortcuts in training like the ones proposed will lead to poor care and poorer outcomes for Washingtonians, which would be a travesty.

AMA and State Medical Associations Do Not Support Independent Practice for Physician Assistants: The American Medical Association does not support the independent practice of physician assistants (http://www.acepnow.com/article/ama-president-dr-steven-stack-talks-physician-shortages-and-apps/). In addition, there are no state medical associations that support independent practice for Physician Assistants.

Physician Assistants Do Not Practice in Rural/Underserved Areas: The motivation for many legislators to support independent practice for PAs is because they expect PAs to fill a need in rural and/or underserved areas.
However, American Association of Physician Assistants (AAPA) data demonstrates that the vast majority of PAs practice in urban areas, so they are not a solution to a perceived lack of access in those areas.

The Solution is More Physicians:
Instead of lowering standards for the independent practice of medicine, please consider these options:
• Working to increase the number of residency positions available to graduating medical students:
  In 2017, 8,640 graduating medical students found no residency position available to them. That’s nearly 8700 physicians who won’t be practicing medicine anywhere, despite their lengthy education.
• Increase incentives for practicing in rural/underserved areas: Physicians graduate with staggering student loan burdens. Finding solutions that help alleviate that burden and increase the number of physicians practicing in rural/underserved areas is critical.
We all have the same goals: patient safety and access to excellent care.

Colleen O’Kelly Priddy, MD
University of Washington-trained general surgeon

95. I am writing to oppose HB 1771, creating a "Doctor of Medical Science" Degree in Washington, which would lead to independent practice of physician assistants. As a fully trained and board certified surgeon, I understand the complexities of medical care in the modern era. I also understand the shortage of physicians in many geographic areas. I assure you, that lowering the standard and allowing non-physicians independent practice will NOT be good for the citizens of Washington. There are no shortcuts that are safe. Medical School is four years, followed by extremely rigorous residency, lasting three to seven years. An individual who desires to practice medicine independently should go to medical school. The title "physician assistant" very clearly states that the education was designed to work with a supervising physician, not independently.

There are viable solutions to the physician shortage and access issues that do not lower the standard to practice. I recommend states issuing loan repayment assistance to physician who commit to serve their underserved population. Another potential is a tax benefit to physicians working in underserved areas. We need to increase the number of residency spots nationwide, so we will not have a physicians shortage, with incentives for all specialties to enter underserved areas.

There are states where mid-level providers have independent practice, mostly nurse practitioners. Years of data demonstrate that those states do have NOT have an increase to access in underserved areas. The mid level providers are more likely to work in urban centers. Also, states with independent mid level practice have higher costs of health care, as their are more expensive imaging and other studies ordered by providers who do not have the scope of knowledge and experience physicians do.

Lastly, it is important to note that every patient deserves a fully trained physician. Underserved areas tend to have more poverty, and people in poverty stricken areas deserve the same high standard all people do. Let us not lower the standard and create shortcuts for practicing medicine. There are no safe shortcuts.

Thank you for your time. I am happy to speak with you personally more about this. Do not hesitate to contact me.

Alexandra B. Roginsky, MD, FACS

96. I am writing in strong opposition of bill HB-1771. There is nothing that a doctorate of medical science will provide to the community other than complete confusion for patients and pave the way for deceitful medical practice by lesser trained individuals. Please keep the sanctity of the Doctor of Medicine alive by
voting against this bill supporting the Doctorate of Medical Science. Please protect healthcare for your citizens and those who wish to enter and work in medicine.

Dr. Diana Krblich (physician)

97. This is a letter to confirm that Washington State HB 1771 is a horrible bill for people in the state of Washington. Medicine is entering a dark age, much like the pharmaceutical industry prior to the advent of the FDA. Many providers are entering the market with half or less of the traditional physician training levels and these providers have little non-biased empiric data to support that they are safe and will not injure patients.

Most data supporting mid-level practitioners comes from the Nurse Practitioner movement which has a strong history of conflicted research during which the authors themselves have financial gain from independent practice. In addition the IOM Future of Nursing report on NPs and PAs was prepared with "unprecedented" funding from the Robert Wood Johnson Foundation. An institution that is heavily embedded with staff from the American Nurses Association who again would all benefit from the financial windfall of independent practice. The veracity of the report and the failure to reach consensus on its final recommendations were shown when the AMA and other medical societies were not sponsors of the final draft of the report.

Physician's Assistants were designed to be part of care team led by physicians and were allowed to have much less training because as assistants they would be trained on the job by physicians who led the team. Why would physicians agree to continue to train such providers if they were forced to train physician competition, under their liability license, and for little or no payment??? This bill sets off an unnecessary turf war where patients are the true losers when they are injured by a fractured team.

Brian Wilhelmi MD

98. My name is Pierce Trumbo, and I am a physician at Vanderbilt University Medical Center, in Nashville, Tennessee, who recently became aware of the Doctor of Medical Science program under consideration by the Washington State Department of Health. Because Tennessee is considering a similar bill (SB 850), I wanted to write you all to convey my strong opposition to the proposed DMD program.

After reviewing the information on your website, I understand that one reason for the DMD proposal is the shortage of medical providers caring for underserved populations. This is, of course, a valid concern that must be addressed at both the state and federal levels. However, I strongly doubt that the DMD program will provide a viable solution to our provider-shortage problem. Instead, I believe it is more likely to compromise patient care and worsen existing inequalities in our system.

As you know, primary care physicians complete at least four years of medical school and three years of residency, frequently working more than 70 hours per week. Ultimately, the reason for such arduous training is patient care. As a primary care physician, I must be aware of a wide range of diseases and management options to keep my patients safe and to optimize their long-term health. While I have tremendous respect for my physician assistant and nurse practitioner colleagues, I do not see how most independently mid-level providers, with minimal additional training, would be capable of providing similar care.

Additionally, the DMD proposal, if passed, is likely to worsen the existing inequalities in our healthcare system and create a second-tier health system for those who lack consistent access to regular healthcare. Worse still, I worry that the large corporations will be incentivized to hire mid-level providers in lieu of physicians, thus sacrificing patient care for profit.
I would encourage the Washington State Department of Health to reject the proposed DMD program. Thank you for your consideration of my letter, and, if I can be of any help moving forward, please do not hesitate to contact me via email or phone.

S. Pierce Trumbo, MD, Vanderbilt University Medical Center

99. I know that this bill is not before you yet and I have written to sunrise@doh.wa.gov as well. It is critically important that this concept/philosophy not be perpetuated in the state of Washington. Primary care of the undifferentiated patient is the most challenging job in medicine. The idea that you can train a physician assistant to be equivalent to an independent primary care physician is ridiculous.

I can provide dozens of examples of physician assistants and advanced practice nurse practitioners that provide suboptimal care because they "do not know what they don't know." Washington State families deserve well trained physician based care. There is no replacement for the rigors of medical training. It takes time, supervision and 10,000 or more hours of structured clinical training to earn your independence as a physician.

We all need to work towards a system in which physician led teams can optimize health care delivery.

Please support expansion of primary care medical resident education. Physicians need you to support ways to reduce physician administrative burden so that we can treat more patients not computers. We need legislative support to make it financially possible for primary care physicians to survive in rural Washington. Please support truth in advertising, our patients need to understand that a chiropractor in Kirkland that calls himself doctor is not trained to treat non-existent thyroid disease.

I would be happy to provide more concrete information or contact with physician leaders who are better explaining the details.

Dr. Christine Logar

100. I am writing you as a concerned physician regarding HB-1771 which intends to give physician assistants (PAs) full practice authority and create a new "Doctor of Medical Science Degree".

As a physician who has worked with PAs in multiple capacities, I cannot stress how dangerous this proposal is to patient safety. Though PAs serve a very important role in healthcare, they are not trained nor educated thoroughly enough to practice without physician oversight. To be objective, PAs have thousands of less clinical hours of training than a physician does after just one year of their residency and tens of thousands of less clinical hours of training than a physician does after completion of their residency (and all residencies are now a minimum of 3 years following completion of medical school). Besides hours of clinical training, the expectation of the training is completely different. Physicians are trained to become independent practitioners and accept full responsibility and liability; PAs are not trained in this way as their very name describes.

Secondly, establishing a degree whereby another "doctor" is created arbitrarily will further confused what is already a nebulous state in healthcare. Patients deserve to know what training and education their healthcare provider has immediately upon introduction.

I understand that PAs and their counterparts, nurse practitioners, are hoped to fill the physician shortage and provide care in rural areas, however, allowing these practitioners to practice independently with inadequate education and training is not the answer. I hope that you will make the right decision for patients of all walks of life regardless of where they live. Americans everywhere deserve better healthcare; they deserve physician lead care.
Crystal Bowden-McKay, MD

101. I would like to register my complete opposition to allowing physician assistants to independently practice medicine. Their training is a small fraction of a primary care doctor's education. They are not experienced or educated enough to function autonomously. If they wish to do so, there is a channel for that. It is called medical school: a four year curriculum, and 10s of thousands of hours of hands on experience in one's specialty, as well as multiple step examinations that test competency at every level.

There is simply no comparison. The "Doctor of Medical Science" degree is merely another attempt to obfuscate the credentials of the health care provider, written by someone who stands to highly profit from its implementation. Please do the right thing and protect your constituents by ensuring they see a fully trained physician for their health care, with the ASSISTANCE of a mid level provider.

Dr. Tina Kinsley, MD, FAAD

102. I am writing to OPPOSE HB-1771, the proposal that would create a new “Doctor of Medical Science” Degree and give PA’s full practice authority.

The difference between physicians and physician assistants is immense. Physicians are made to go through the most rigorous of standards and training, and they are held highly accountable for everything that they do. From the start they have to achieve the highest grades and scores to even get into medical school, and then they have to survive the rigors of medical school in itself. The amount of knowledge that is learned in the four years of medical school is often equated to “Drinking water from a fire hydrant”. This learning is repeated and repeated as medical students go from book learning to clinical rotations, and then onwards after medical school when they go to residency.

If medical school is like drinking water from a fire hydrant, then residency is in essence, like “boot camp”. Residents are made to work long hours, carry many patients, and learn to make complex treatment decisions. In effect, they are already physicians, practicing as such, with intensive supervision from attending physicians.

Over time, what is also learned by physicians is that medicine is humbling. The more you know, the more you realize you don’t know. We know our limitations, we know when to seek consultations, ask for help etc.

When you go to see your physician, you know there is a certain guarantee of quality and training. You know what it means when you see MD or DO next to their name.

When talking about the creation of this very confusing title (Doctor of Medical Science) that allows people with much less training and knowledge and standards than physicians to practice independently, we are in effect, doing a huge disservice to our patients. A lay person will see this title and think “Oh yes, I’m seeing a doctor.” Unfortunate how misused the title “doctor” is these days. Nowadays your doctor could be a nurse practitioner, a physician’s assistant, a naturopath, a chiropractor…

Why do we even consider doing something like this to our patients? Why provide anything less than the best? Would you send your infant, child, mother, brother to see someone with substandard training, masquerading around as a doctor? Would you honestly do that? Would you lie to them and tell them that person is a “doctor”?

There is indeed a doctor shortage. There are proposals to increase funding for resident spots and increase the doctors in the US. Right now in 2016, 12,000 doctors did not match into residency programs – there
just weren’t enough slots. Let’s address the real problem here and not try to slap on a sloppy solution that will do nothing except to harm patients.

The same letter submitted separately by:
Laura Kendall, MD
Rajesh K. Sharma, MD, Alliance Spine and Pain Management, PLLC
Diplomate Board of Anesthesia, Diplomate Board of Pain Management

103. I am writing to strongly OPPOSE HB-1771. This proposed short cut to independent practice and “Doctor of Medical Science” is just that: a short cut. I am a practicing physician. I went to 4 years of medical school and 3 years of residency. It was difficult. I worked very hard in college to make the grades required to make it into medical school. In medical school, we took 2-3 times more class hours than an average college student. Residency was 80 hours/week for 3 years, long hours away from family, under constant scrutiny. My medical and board certification process consisted of three different high stress written tests during medical school and residency, followed by a written test and oral board exam after completion of a certified residency program.

Further, bestowing the “Doctor of Medical Science” is at best confusing, at frankly could be considered false advertising. When you go see your physician, you know the MD or DO means that they have the highest training possible. Passage of HB-1771 is not the best way to preserve safe and effective access to medical care.

Matthew W Porter MD

104. Please oppose HB-1771. Physician assistants are not physicians. To allow them independent practice, the full responsibility of patients' lives, would be a disservice to your constituents and to my patients.

If they desire fully independent practice authority, and all of the risk and responsibilities that come with it, they should be fully trained as physicians via MEDICAL SCHOOL. "Cheaper" staff is NOT better! Medical "Cliffs notes" + a PhD substitute do not a true physician make.

Please stop this nonsense before there are no doctors left to care for you when you or your descendants fall ill.

Dr. Elizabeth Zona

105. I am writing you in opposition to your bill (SB 850 aka Doctor of Medical Science Act) which creates an independent pathway for physician assistants (PA) to practice medicine independently in the state of Tennessee. The proposed Doctor of Medical Science degree (DMS) was created for those interested in non-clinical research work and seems to have been repurposed as a pathway to independent medical practice by midlevel providers. This pathway is a danger to patient safety as the proposed educational pathway dose not even come close to an equivalent educational experience for physicians.

I, myself, was a midlevel provider before I went back to medical school. I recognized the deficits in my training and wanted to take my education further to take care of patients to the best of my ability. I had rigorous training at Emory in Atlanta with some of the best in my field. While I see the utility of midlevel providers, they in no way replace physicians. Our knowledge is deeper and more comprehensive. The current educational pathway for physicians not only includes 4 years of university education, followed by 4 years of comprehensive medical education followed by at least 3 years of intensive and carefully supervised clinical education. The PA education is a gloss of this. Many people ask me, "Why did you go back to medical school" and "Did they let you skip classes in medical school," I went back to medical school from PA school because I noticed the deficits in my training. I knew to be the leader of the team, I needed more training. In no way could my PA classes ever replace my more in
depth and comprehensive medical school classes. There are no short cuts to medical education. While midlevel providers can help facilitate medical care, they in no way can replace physicians and truly it is insulting for graduates of these programs to be called "Doctors".

No field of medicine is "easy" and by implying that primary care is somehow simple and easily mastered with 50 credit hours of lectures devalues the skill and expertise that our colleagues in Internal Medicine, Family Medicine, and Pediatrics have worked too long and hard to gain. There is a proper pathway to this and only one, Medical School.

As a surgeon and leader, I hope that you see this pathway devalues and undermines the education of yourself and all of us as physicians. I am asking you to rescind your support of this dangerous and flawed proposal that will set the precedent for others to follow.

Dr. Amy Cabbabe, South County Anesthesia Associates, St. Louis, MO

106. I am writing in opposition to your bill (SB 1771- Doctor of Medical Science Act) which creates an independent pathway for physician assistants(PA) to practice medicine independently in the State of Washington. The proposed Doctor of Medical Science (DMS) degree was created for those interested in non-clinical research work and seems to have been repurposed as a pathway to independent medical practice. This is a danger to patient safety as the proposed educational pathway does not even come close to an equivalent educational experience to current primary care medical training.

As a preceptor for Medical Students as well as PA students, I know first-hand the rigorous training necessary to perform the ever more challenging duties of a primary care physician, and the differences in classroom education provided to these students before setting foot in the clinical world. There is absolutely no comparison between the comprehensive, formal, systems based education given to Medical students, compared to the abridged version that a Physician's Assistant Student receives.

The current educational pathway for properly trained primary care physicians, as you know, consists of 4 years of university education, followed by 4 years of comprehensive medical education followed by three years of intensive and carefully supervised clinical education at our nations top academic medical centers. The training outlined in the proposed bill can in no way approach the quality afforded by our current system of medical school followed by residency training. Appropriate accrediting bodies such as the Accreditation Commission on Graduate Medical Education (ACGME) do not exist to oversee the adequacy of the proposed DMS curriculum as a path to independent practice.

Physician assistants play an important role as part of the modern healthcare team, indeed it would be difficult for many offices and hospitals to function without their contributions to the workforce. However, their training pathway is not sufficient to lead to the independent practice of medicine. By implying that “primary care” is somehow simple and easily mastered with fifty credit hours of lectures devalues the skill and expertise that our colleagues in Internal Medicine, Family Medicine, and Pediatrics have worked too hard and too long to gain. There is a pathway for anyone that seeks to gain those skills, and it is served by a proper medical school followed by an accredited residency training program. Anything less jeopardizes the safety and welfare of the citizens of the State of Washington.

This proposed plan that is not in the best interests of the people of the State of Washington and of the highly skilled primary care workforce that serves them. I am asking that you rescind your support for this flawed proposal.

Chantel O'Shea, D.O., Attending Physician, Board Certified- Emergency Medicine
107. I am writing to oppose HB-1771.  

Physician assistant are not doctors. To allow them independent practice is to knowingly condone negligence. Working alongside an expert does not make one an expert, just as flight attendants cannot turn around tomorrow and say they wish to pilot the plane by taking a "Cliff Notes" version of the education needed to become the expert.

Please oppose HB-1771 and demonstrate to your constituents that there is no adequate substitute for a well educated professional to take on the intricacies of the human body, that you care that someone has dedicated their lives and sacrificed their time to fully immerse themselves into a full, unshortened, and unedited curriculum dedicated to being as thorough and fully equipped physician as possible.

Please show that short-cuts in life are not worth a shortened life due to inadequate superficial care as may occur under HB-1771.

Visanee Darin, M.D.

108. As a future MD, I am emailing to express my concern regarding this bill. After undergoing to the rigors of medical school, I know that patient's lives are in my hands and that this bill would not lead to safe practice. Allowing a mere two more years of training would not prepare PAs for the full responsibilities of a physician. Additionally, it would not serve the goal of providing more rural healthcare providers. There is not enough incentive for PAs to go to rural communities, which is something that will not change by allowing for more independent practice.

This is a very important and timely issue that affects everyone. Please reject this proposal for the health and safety of patients everywhere.

Jessie Ho, Texas A&M HSC College of Medicine, MS3, 2D Lt United States Air Force

109. I am writing to OPPOSE HB-1771, the proposal that would create a new “Doctor of Medical Science” Degree and give physician assistants full practice authority.

I am a child and adolescent psychiatrist. To train for this work, I attended medical school for 4 years, completed a 4 year residency and a 2 year fellowship. In that training, it was routine to work 80+ hours a week learning my craft. Entry into medical school is extraordinarily competitive; physician assistant programs are far less so. Their training is much less rigorous, and prepares them to do what they are trained to do: ASSIST physicians. Not become physicians through back door legislation.

You may or may not know that there is an epidemic of "midlevel" practitioners who are clamoring to call themselves the equal of physicians: optometrists who seek to prescribe and perform injections INTO THE EYE; psychologists who seek prescribing authority without one iota of medical training; nurse anesthetists who are rapidly replacing the far more experienced physician anesthesiologists in the OR, often with dire consequences. These midlevels have been emboldened by their own professional organizations, who are well funded and lobby hard for the "right" to be considered equal in training and expertise to a physician.

But there are no shortcuts to physician training. Midlevels who seek to practice medicine should go to medical school and endure residency and subspecialty training. "Access" is not a reason to award physician-level responsibilities to those who DO NOT HAVE THE TRAINING to possibly match that of a physician.

I'm fortunate that in my state of Oregon, just south of the great state of Washington, our governor, Kate Brown, is pledging to veto the psychologist prescribing bill on her desk. As she so correctly points out:
“There remains a lack of evidence that psychologist prescribing will improve access or quality of care,” Brown said in a written statement. “While prescription drugs may be appropriate mental health treatment for some patients, there are also significant health risks with some drug therapies.”

Join Oregon in rejecting a wholly inappropriate request to grant physician privileges to those who are not physicians.

Eileen K. McCarty MD, MA, Child & Adolescent Psychiatrist
Providence Willamette Falls Medical Center, Oregon City, OR

110. I have a Doctor of Medicine (MD) from Oregon Health and Sciences University and Master of Public Health in Infectious Diseases from Kansas State University. I am a strong advocate of patient rights in Oregon and Washington and participate in the Washington patient advocate association for this reason.

As an independent Patient Advocate and Medical Doctor, I OPPOSE the SUNRISE HB 1771 to be proposed in Washington state.

The proposed Doctor of Medical Science (DMS) degree was created for those interested in non-clinical research work and seems to have been repurposed as a pathway to independent medical practice. This is a danger to patient safety as the proposed educational pathway does not even come close to an equivalent educational experience to current primary care medical training. According to the national Residency matching Program, there are more that 7000 MD/DOs that are not able to get residency training and cannot work independently in the state of Washington without 2 YEARS of residency training. These graduate physicians are trained with much more clinical experience and knowledge than the Physician Assistant (PA) route. The current educational pathway for properly trained primary care physicians, consists of 4 years of university education, followed by 4 years of comprehensive medical education followed by three years of intensive and carefully supervised clinical education at our nation’s top academic medical centers. Appropriate accrediting bodies such as the Accreditation Commission on Graduate Medical Education (ACGME) do not exist to oversee the adequacy of the proposed PA curriculum as a path to independent practice.

In 2015, Washington state proposed HB 2343 to allow graduate MDs to practice with a limited license. SEE: http://app.leg.wa.gov/billsummary?BillNumber=2343&Year=2015 To pass HB 1771 is discriminatory against graduate physicians. If you allow PAs to practice independently, you should by right allow all graduate MDs to practice independently. I am asking for equal opportunity in the workforce. PAs in Washington are requesting equal rights and privileges as MD/DOs and wish to operate under the same standards as MDs but do not have the same breadth of knowledge or experience as MD/DOs. Passing HB 1771 will allow lower standards for licensure than an MD/DO which makes their participation in the market easier than graduate DO/MD’s. In order to have equal application of the laws without discrimination between MD/DOs and PAs, fair and equitable access would call for all groups to practice with the same standards or a denial of the entitlement of independent practice to a PA.

Physician assistants play an important role as part of the modern healthcare team, indeed it would be difficult for many offices and hospitals to function without their contributions to the workforce. However, their training pathway is not sufficient to lead to the independent practice of medicine. By implying that “primary care” is somehow simple and easily mastered with fifty credit hours of lectures devalues the skill and expertise that our colleagues in Internal Medicine, Family Medicine, and Pediatrics have worked too hard and too long to gain. There is a pathway for anyone that seeks to gain those skills, and it is served by a proper medical school followed by an accredited residency training program.

Sara Bubenik, M.D., M.P.H.
111. It has come to my attention that the House of Representatives of Washington State is considering supporting the development of a 'Doctoral of Medical Sciences' program that essentially turns the 2-year PA program into a doctoral degree to allow for independent practice of PAs. I am writing to strongly encourage you to vote against this measure as it is putting the good constituents of Washington State at risk of inadequate healthcare.

It should be noted that Physician Assistant programs in the United States were not and never have been created for independent practice. This is why the programs are 2 years in length and PAs have historically worked in collaboration and under the supervision of a licensed physician without the liability or medical complexity the supervising physician takes on. The Physician Assistant program does not, in any way, have the same depth or breadth of training and clinical exposure with that of the Doctor of Medicine (MD) training. We should not consider taking shortcuts to quality medical care for the residents of Washington State; they deserve better.

There is this misconception that somehow primary care is "easy" and that these shortcuts will address the shortage of physicians. Primary care is not simple nor is it easy. This field of medicine is the field in which physicians are the first to see all and every single kind of complaints. That means the job of the primary care physician is to be the first to diagnose and this requires a vast knowledge base, which is attained through 4 years of intense medical school training and at least 3 years of residency, in addition to experience as an independent practicing physician. I can assure you, as a resident physician, that this 2 year Doctoral of Medical Sciences is not at all sufficient to develop the skills and knowledge necessary to provide primary care. As a first year resident, I am humbled by how much I still must learn even after completing 4 years of a rigorous medical school education.

As Congressmen and women, you may have legislative aides who work with you to support legislative efforts in your state. They are incredibly important, yet function differently than you and their training and experience is also quite different. Do you believe they have the knowledge and experience to function independently as Congressmen and women for the United States? From my understanding, the function of the legislative aide is somewhat analogous to the Physician Assistant in the medical field, which is part of why I find this bill so alarming. From speaking with colleagues who had worked previously as Physician Assistants, I realized that they, too, are alarmed about this bill because they know that their PA school and work experience was not sufficient to be an independently practicing healthcare provider. They then went to medical school and residency, realizing how stark the differences in training were.

We do have a healthcare provider shortage in America, but HB 1771 is not the appropriate solution. Support GME funding and innovative solutions to expand the physician workforce. Stand with physicians who believe in giving your constituents the excellent healthcare they deserve.

Crystal Nnenne Azu, MD MPH, Internal Medicine Resident, Indiana University Health System

112. As a MD specializing in pediatric hospital medicine, I work with many mid-levels such as PAs when they call me for pediatric consults. They are pleasant, well-meaning, and skilled in many ways, but their level of knowledge and expertise by no means equates to my many thousands of hours of schooling and training. They invariably express not being entirely comfortable with pediatrics, and gratitude for my recommendations. Mid-levels need oversight for patient safety and for the safety and longevity of their own careers. Giving PAs or NPs autonomy they are not adequately prepared for will only be more costly-in dollars, productivity, and public health--to the state of Washington.

Bronwyn, Lead Pediatric Hospitalist, Kaiser Doernbecher Children's Hospital, OHSU Licensed in Oregon and Washington
I am writing to OPPOSE HB-1771, the proposal that would create a new “Doctor of Medical Science” Degree and give physician assistants full practice authority.

I am an anesthesiologist and have been in practice for the last 8 years. To train for this job, I attended medical school for 4 years, completed a 4 year residency and a 1 year fellowship in regional anesthesia and acute pain medicine. In that training, it was routine to work 80+ hours a week. Entry into medical school is extraordinarily competitive; physician assistant programs are far less so. Their training is much less rigorous, and prepares them to do what they are trained to do: ASSIST physicians. Not become physicians through back door legislation.

You may or may not know that there is an epidemic of "midlevel" practitioners who are clamoring to call themselves the equal of physicians: optometrists who seek to prescribe and perform injections INTO THE EYE; psychologists who seek prescribing authority without one iota of medical training; nurse anesthetists who are rapidly replacing the far more experienced physician anesthesiologists in the OR, often with dire consequences. These midlevels have been emboldened by their own professional organizations, who are well funded and lobby hard for the "right" to be considered equal in training and expertise to a physician.

My father in law is a physician assistant. He is very good at his job as he has worked for 20+ years. Despite his experience, he agrees that physician oversight is extremely important and is also opposed to the bill.

There are no shortcuts to physician training. Midlevels who seek to practice medicine should go to medical school and endure residency and subspecialty training. "Access" is not a reason to award physician-level responsibilities to those who DO NOT HAVE THE TRAINING to possibly match that of a physician. It would do a great disservice to our society to have mid-levels practicing medicine as physicians WITHOUT the proper training.

I'm fortunate that in my state of Oregon, just south of the great state of Washington, our governor, Kate Brown, is pledging to veto the psychologist prescribing bill on her desk. As she so correctly points out: “There remains a lack of evidence that psychologist prescribing will improve access or quality of care,” Brown said in a written statement. “While prescription drugs may be appropriate mental health treatment for some patients, there are also significant health risks with some drug therapies.”

Join Oregon in rejecting a wholly inappropriate request to grant physician privileges to those who are not physicians.

Amy DeRoche MD

I am writing to OPPOSE HB-1771, the proposal that would create a new “Doctor of Medical Science” Degree and give PA’s full practice authority.

The difference between physicians and physician assistants is immense. Physicians are made to go through the most rigorous of standards and training, and they are held highly accountable for everything that they do. From the start they have to achieve the highest grades and scores to even get into medical school, and then they have to survive the rigors of medical school in itself. The amount of knowledge that is learned in the four years of medical school is often equated to “Drinking water from a fire hydrant”. This learning is repeated and repeated as medical students go from book learning to clinical rotations, and then onwards after medical school when they go to residency.

If medical school is like drinking water from a fire hydrant, then residency is in essence, like “boot camp”. Residents are made to work long hours, carry many patients, and learn to make complex treatment
decisions. In effect, they are already physicians, practicing as such, with intensive supervision from attending physicians.

Over time, what is also learned by physicians is that medicine is humbling. The more you know, the more you realize you don’t know. We know our limitations, we know when to seek consultations, ask for help etc.

When you go to see your physician, you know there is a certain guarantee of quality and training. You know what it means when you see MD or DO next to their name.

When talking about the creation of this very confusing title (Doctor of Medical Science) that allows people with much less training and knowledge and standards than physicians to practice independently, we are in effect, doing a huge disservice to our patients. A lay person will see this title and think “Oh yes, I’m seeing a doctor.” Unfortunate how misused the title “doctor” is these days. Nowadays your doctor could be a nurse practitioner, a physician’s assistant, a naturopath, a chiropractor…

The issuance of doctorates to non-physicians intends to confuse patients into accepting an inferior standard of healthcare, by invoking the goodwill associated with the title of medical doctor. It is the worst kind of bait and switch possible, and would be considered impossible in any other profession. Are there "Doctorates of Paralegal Jurisprudence"? No the expectation is that if someone desires to practice law independently, they would complete the requisite training. Please do not be a part of reducing the quality of our healthcare further.

Why do we even consider doing something like this to our patients? Why provide anything less than the best? Would you send your infant, child, mother, brother to see someone with substandard training, masquerading around as a doctor? Would you honestly do that? Would you lie to them and tell them that person is a “doctor”?

There is indeed a doctor shortage. There are proposals to increase funding for resident spots and increase the doctors in the US. Right now in 2016, 12,000 doctors did not match into residency programs – there just weren’t enough slots. Let’s address the real problem here and not try to slap on a sloppy solution that will do nothing except to harm our patients.

Same letter submitted by:
Ashish G. Shanbhag, M.D.
Meenu Potdar M.D.

115. My name is Sharon D'Souza and I am a physician living in Oregon and practicing in the State of Washington. I am in good standing with both the Oregon and Washington State Medical Boards. I am writing to strongly urge you to OPPOSE HB-1771, the proposal that would create a new “Doctor of Medical Science” Degree and grant full practice authority to Physicians Assistants.

You may or may not know that there is an epidemic of "midlevel" practitioners who are clamoring to call themselves the equal of physicians: optometrists who seek to prescribe and perform injections INTO THE EYE; psychologists who seek prescribing authority without one iota of medical training; nurse anesthetists who are rapidly replacing the far more experienced physician anesthesiologists in the OR - often with dire consequences. These midlevels have been emboldened by their own professional organizations, who are well funded and lobby hard for the "right" to be considered equal in training and expertise to a physician.

But there are NO SHORTCUTS to physician training. Midlevels who seek to practice medicine should go to medical school and endure residency and subspecialty training. "Access" is not a reason to award physician-level responsibilities to those who DO NOT HAVE THE TRAINING to possibly match that of
a physician - in this effort to supposedly increase 'access', things like 'quality of care' and 'patient safety' will be sorely compromised.

I'm fortunate that in my state of Oregon, just south of the great State of Washington, our governor, Kate Brown, is pledging to veto the psychologist prescribing bill on her desk. As she so correctly points out: “There remains a lack of evidence that psychologist prescribing will improve access or quality of care,” Brown said in a written statement. “While prescription drugs may be appropriate mental health treatment for some patients, there are also significant health risks with some drug therapies.”

Join Oregon in rejecting a wholly inappropriate request to grant physician privileges to those who are not physicians. Protect the patients of Washington and reject this dangerous bill.

Sharon D'Souza, MD, MPH

116. I am writing to OPPOSE HB-1771, the proposal that would create a new “Doctor of Medical Science” Degree and give physician assistants full practice authority.

I am a neurologist. To train for this work, I attended medical school for 4 years, completed a 4 year residency and a 2 year fellowship. In that training, it was routine to work 80+ hours a week learning my craft. Entry into medical school is extraordinarily competitive; physician assistant programs are far less so. Their training is much less rigorous, and prepares them to do what they are trained to do: ASSIST physicians. Not become physicians through back door legislation.

You may or may not know that there is an epidemic of “midlevel” practitioners who are clamoring to call themselves the equal of physicians: optometrists who seek to prescribe and perform injections INTO THE EYE; psychologists who seek prescribing authority without one iota of medical training; nurse anesthetists who are rapidly replacing the far more experienced physician anesthesiologists in the OR, often with dire consequences. These midlevels have been emboldened by their own professional organizations, who are well funded and lobby hard for the "right" to be considered equal in training and expertise to a physician.

But there are no shortcuts to physician training. Midlevels who seek to practice medicine should go to medical school and endure residency and subspecialty training. "Access" is not a reason to award physician-level responsibilities to those who DO NOT HAVE THE TRAINING to possibly match that of a physician.

I'm fortunate that in my state of Oregon, just south of the great state of Washington, our governor, Kate Brown, is pledging to veto the psychologist prescribing bill on her desk. As she so correctly points out: “There remains a lack of evidence that psychologist prescribing will improve access or quality of care,” Brown said in a written statement. “While prescription drugs may be appropriate mental health treatment for some patients, there are also significant health risks with some drug therapies.”

Join Oregon in rejecting a wholly inappropriate request to grant physician privileges to those who are not physicians.

Dr. Leenu M. Pallickal, M.D., Board Certified Neurologist
Diplomate, American Board of Psychiatry and Neurology

117. To start a DMS program for physician assistants would be detrimental for several reasons, and I'm going to tell you about some of them. As in most things in life, taking cheap shortcuts leads to poor outcomes. Do we really want to jeopardize the healthcare of our patients? I am writing this to represent many of my
colleagues who are out there sun up to sun down caring for patients and furthering the study of medicine. Please, do not allow a DMS program in your state.

The first and most obvious is that people without the training of a physician would be getting a doctorate degree in an attempt to mislead patients by calling themselves "doctor" in a clinical setting. Patients will think they are being treated by someone who was in the top of his or her college class, someone who aced standardized exams, someone who spent thousands of hours and more standardized testing in a four-year medical school, and someone who spent a minimum of 12,000 hours (equivalent of more than 6 years of a full time job) of on-the-job training by older physicians with years and years of experience when in all actuality, they will be getting someone who maybe did not have the grades or the grit or the dedication or who did not want to make the investment of getting the most in depth medical training to earn the title of doctor and lead healthcare decisions. Patients, especially when ill, are often times not savvy enough to sort out who is who, and the physician assistants getting a DMS would be able to mislead them in to thinking they were getting a real physician. This is already being attempted by many many nurse practitioners.

The second is that this is an unnecessary waste of money. Physician assistants get very basic training to do just that- assist physicians who supervise them. It is not necessary to get a doctorate degree for that. Thinking they will fill primary care gaps is absurd. Studies have shown that midlevel providers rarely go to these rural areas without strong financial incentives. They also over-utilize diagnostic testing, imaging, sub-specialty referral, and over-prescribe. I would be happy to provide references for studies that show this.

I would not want my family member mislead especially in a time of need, and I'm sure you would not want that for yours. When it comes to patients' lives, they need someone who has invested the time to learn how to get them diagnosed and properly treated. Please do not support this DMS program.

Kelly Forb, MD, Internal Medicine in Ohio and North Carolina

118. I am a physician, and I am writing to express my opposition to HB-1771, the bill that would create a new "Doctor of Medical Science" degree for physician assistants. I am board certified in psychiatry. The process of becoming a psychiatrist involved four years of medical school, four years of General Psychiatry residency, and then a one year fellowship in a subspecialty of psychiatry. Even after so much training, I would never attempt to perform work outside of the scope of my specialty without the involvement of a physician who had specialized in that area of medicine. I think most people can easily see that it would be inappropriate for me, as a psychiatrist, to try to provide prenatal care to pregnant women without collaborating with an obstetrician, to give advice on heart disease without the involvement of a cardiologist, or to try to treat skin cancer without the expertise of a dermatologist.

Even though all physicians receive basic training in broad range of medical specialties, we recognize that the residency training that physicians undergo to specialize in one area of medicine is necessary to develop the knowledge base essential to provide excellent patient care. If a physician decides to switch from one specialty to another, they have to complete another residency, because there is no shortcut to obtaining this specialized knowledge. The training process of a physician is as long and rigorous as it is because it takes experience and a broad knowledge base to recognize the patients whose illnesses do not present in a classic textbook way, who require more investigation or a different approach to treatment.

That is why I do not feel it is appropriate for physician assistants to practice across different specialties of medicine without the oversight of a physician. Physician assistant training was never intended to allow them to do the work of a physician independently, but instead to work as part of a team with physician oversight. Giving PAs the ability to practice medicine independently destroys this team approach and pits physicians and PAs as competitors.
Additionally, I am concerned that creating a "doctor" degree for physician assistants will lead to confusion for patients. Just as we trust that someone who calls themselves a "lawyer" has specific knowledge and training that is demonstrated by completing law school and passing the bar exam, I feel it is important for patients to be able to trust that when they are dealing with a "doctor" in a medical setting, they are receiving care from someone who has undergone the rigorous training of medical school and residency that a physician has undergone. If patients discover that the "doctor" they are being seen by is someone who in fact has a much lower level of training, they may quite possibly feel deceived or lose trust in their healthcare team. I do not think that it is fair to place patients in that position when they are ill and vulnerable.

Karole Kuslak, DO, Psychiatry

119. I am writing to voice my firm opposition to the future proposal of allowing independent medical practice rights to Doctors of Medical Science.

I am a physician. I completed undergraduate studies, obtained a medical degree, as well as a a three-year residency in Internal Medicine for a total of 12 years of post-high school education. During my medical training and residency, I logged well over 20,000 hours of clinical training and research.

Compare this to a physician assistant and nurse practitioner. By comparison, a nurse practitioner has approximately six to eight years of post-high school education. Their clinical education hours amount to approximately 1000 to 1500. A physician assistant has approximately six to six and a half years of post-high school education. They amount to approximately 2000 hours of clinical education. This is at the Masters level.

According to the Lincoln Memorial University Debusk College of Osteopathic Medicine, at which Mr. Moran and Mr. Cushing are faculty, adding the Doctor of Medical Sciences degree (which can be completed completely online according to the announcement on their web site) will add 50 credit hours and no clinical education hours, keeping the clinical education hours at approximately 2000 for the entire educational course.

Please keep in mind that we are currently dealing with the fall-out from Nurse practitioners who lobbied for independent practice in many states. Patients have suffered as a result of this due to the mistakes they make when their medical knowledge is simply lacking. There have been several horror stories which. I am able to provide examples if you need them.

With this in mind, there is just no way this on-line program with an additional 50 online credit hours can be sufficient to provide the necessary training needed to practice independently as a primary care provider. It is just not possible. As mentioned above, a primary care physician has about 20,000 clinical hours.

Also keep in mind that states that have independent practice for nurse practitioners have not demonstrated any increased access to primary care in Rural areas. Therefore, one can safely assume that creating this degree will not increase access to primary care.

In addition, the "Doctor of medical science" degree will only cause more confusion for patients who will not know the difference between this and a medical degree. This will open the door for the misleading of patients. Creating this program is just not in in the best interest of patients.

Providing Primary Care with under trained providers, and giving them full Medical Practice rights, as is suggested by this hearing, is just not in the best interest of Washingtonians and the USA as a whole.
I strongly urge you to vote against this proposal allowing full Medical Practice rights to Doctors of Medical Science. It is dangerous for Washingtonians and dangerous for the USA as a whole.

Elizabeth Krebs, MD

120. I am a Psychiatrist and work with a group of Physicians who are trying to protect the lives of patients by making sure that they are given the best care by the most qualified professionals. I was made aware of this bill by one of the members of that group. After reviewing the Doctor of Medical Science program at Lincoln Memorial University in Tennessee (as I could not find a program in Washington State), I am urging you to vote No on this bill.

In the description of their program, it explains that Physician's Assistants get less training than Physicians because they are training to work UNDER the direct supervision of a Physician. The Doctor of Medical Science program is then a 2 year ONLINE program that states that it fills the gaps from Physician training. The problem there is that none of Physician training is online. And the tracks that they propose for specialty training are Primary Care, Hospital Medicine and Emergency Medicine. The "equivalent" specialty training for Physicians are a 3 year residency training program in Family Medicine or Internal Medicine where residents are working 80 hrs per week providing direct patient care under the supervision of Physicians to further hone in on their specialty or a 4 year residency in Emergency Medicine in which residents are doing the same. In addition to direct patient care, these residents are receiving didactics and taking yearly in-service examinations to prepare for board examinations in their specialty in order to independently practice. Not mention the additional training that they received as medical students. PAs do not complete a residency. How is this ONLINE training filling in those gaps and adequately preparing PAs to practice independently?

Once these PAs receive their "doctorate" and then proceed to identify themselves in clinical practice as such, patients will be none the wiser that the training of their PA is not the same as the training of an MD/DO/MBBS. Would you know to ask your primary care doctor if they were a trained as a Physician's Assistant or as a Physician? Would you want to take that risk with the care of your loved one?

I understand the need for access in underserved areas but right now as PAs need to work under the supervision of Physicians, there are not a lot of PAs practicing in underserved areas either. Affording them the ability to practice independently will not ensure that they move to these areas either. What it does ensure is that there will be grossly under-qualified practitioners out there providing unsupervised care to some of our sickest patient in Primary Care, Hospital and Emergency room settings. Please find another way to improve access to care by improving the ability for Physicians to become specialty trained and licensed. Please Vote No on HB-1771.

LaShire Diegue, M.D.

121. I am a physician, and I am writing to express my opposition to HB-1771, the bill that would create a new "Doctor of Medical Science" degree for physician assistants.

I am board certified in Pediatric Anesthesiology practicing a superspeciality of pediatric cardiac Anesthesiology. The process of becoming a Pediatric cardiac Anesthesiologist involved four years of medical school, four years of General Anesthesiology residency, and then a one year fellowship for Pediatric Anesthesiology which was followed by 6 more months fellowship super specializing in pediatric cardiac Anesthesiology. Even after so much training, I would never attempt to perform work outside of the scope of my specialty without the involvement of a physician who had specialized in that area of medicine. I think most people can easily see that it would be inappropriate for me, as a pediatric anesthesiologist, to try to provide prenatal care to pregnant women without collaborating with an
obstetrician, to give advice on adults with heart disease without the involvement of a cardiologist, or to try to treat skin cancer without the expertise of a dermatologist.

Even though all physicians receive basic training in broad range of medical specialties, we recognize that the residency training that physicians undergo to specialize in one area of medicine is necessary to develop the knowledge base essential to provide excellent patient care. If a physician decides to switch from one specialty to another, they have to complete another residency, because there is no shortcut to obtaining this specialized knowledge. The training process of a physician is as long and rigorous as it is because it takes experience and a broad knowledge base to recognize the patients whose illnesses do not present in a classic textbook way, who require more investigation or a different approach to treatment.

That is why I do not feel it is appropriate for physician assistants to practice across different specialties of medicine without the oversight of a physician. Physician assistant training was never intended to allow them to do the work of a physician independently, but instead to work as part of a team with physician oversight. Giving PAs the ability to practice medicine independently destroys this team approach and pits physicians and PAs as competitors.

Additionally, I am concerned that creating a "doctor" degree for physician assistants will lead to confusion for patients. Just as we trust that someone who calls themselves a "lawyer" has specific knowledge and training that is demonstrated by completing law school and passing the bar exam, I feel it is important for patients to be able to trust that when they are dealing with a "doctor" in a medical setting, they are receiving care from someone who has undergone the rigorous training of medical school and residency that a physician has undergone. If patients discover that the "doctor" they are being seen by is someone who in fact has a much lower level of training, they may quite possibly feel deceived or lose trust in their healthcare team. I do not think that it is fair to place patients in that position when they are ill and vulnerable.

Dr Aparna Phadke

122. I am writing to oppose HB 1771, creating a "Doctor of Medical Science" Degree in Washington, which would lead to independent practice of physician assistants. I understand the complexities of medical care in the modern era. I also understand the shortage of physicians in many geographic areas. I assure you, that lowering the standard and allowing non -physicians independent practice will NOT be good for the citizens of Washington. There are no shortcuts that are safe. Medical School is four years, followed by extremely rigorous residency, lasting three to seven years. An individual who desires to practice medicine independently should go to medical school. The title "physician assistant" very clearly states that the education was designed to work with a supervising physician, not independently.

There are viable solutions to the physician shortage and access issues that do not lower the standard to practice. I recommend states issuing loan repayment assistance to physician who commit to serve their underserved population. Another potential is a tax benefit to physicians working in underserved areas. We need to increase the number of residency spots nationwide, so we will not have a physicians shortage, with incentives for a all specialties to enter underserved areas.

There are states where mid - level providers have independent practice, mostly nurse practitioners. Years of data demonstrate that those states do have NOT have an increase to access in underserved areas. The mid level providers are more likely to work in urban centers. Also, states with independent mid level practice have higher costs of health care, as their are more expensive imaging and other studies ordered by providers who do not have the scope of knowledge and experience physicians do.

Lastly, it is important to note that every patient deserves a fully trained physician. Underserved areas tend to have more poverty, and people in poverty stricken areas deserve the same high standard all people
do. Let us not lower the standard and create shortcuts for practicing medicine. There are no safe shortcuts.

Alexander Tsesis, Simon Chair in Constitutional Law and Professor, Loyola University School of Law

123. I am a psychiatrist and am writing in opposition to the proposal submitted by the HB-1771 that would create the new “Doctor of Medical Science Degree” and give physician assistants the authority to prescribe without physician oversight.

After completing rigorous graduate studies in anatomy, physiology, pathology and neuroscience, psychiatrists go on to complete at least 10,000 hours of clinical training. Some of us complete more than 30,000 additional hours beyond that. No other health care professionals meet these standards. I personally completed a medical degree and greatly value my education. It was only my medical training, residency, and fellowship that prepared me to understand medications and safely prescribe them independently.

Please do not allow the state of Washington to fall victim to this dangerous proposal.

Elizabeth Wassenaar, MD | Psychiatrist, Conifer Track II

124. I am a dermatologist of 10 years experience since graduating residency. Formally in New York City I was the director of the department of Derm for an underserved bro government hospital where I oversaw to physician assistance and Dermatology residents. The education could not compare even at that level.

For the last six years in private practice in south Florida, I had the experience of training physician assistant students in their final months before graduation. It is astounding to see the lack of formalized education they receive from various schools here in South Florida as well as their inability to evaluate drug interactions, write a simple medical note, understand the nuances of diagnosis and treatment protocols. However they are expected from graduation to be able to obtain a position within medicine and be treated as a physician without undergoing the next necessary step which would include anywhere from 1 to 6 additional years of intense specialty or general training in their chosen (or more importantly evaluated For aptitude) field. Instead they're able to flip-flop between specialties, and are often given or fight for autonomy much too early to develop sound diagnostic skills that are essential to becoming a confident and effective provider. In fact the term provider has become synonymous with either a nurse practitioner or physician assistant or physician. This further complicates the medical landscape as patients are no longer aware if they are under the care of a proper physician from a formal medical school or a mid-level education. Moreover, online doctorate programs are popping up around the nation, directed at PAs and RNs, so that within one year of online training these non-physicians may attempt to call themselves doctor In the medical setting. This is just one of the dangerous trends that will begin with the initial steps toward independent practice by those who have not received any adequate or formalized training in the way that we know modern Medicine now and will lead to harmful outcomes for patients who will never know how these pseudodoctors came about. Please vote no to independent physician assistant practice.

Marcy Alvarez DO
Board certified dermatologist

125. I am a psychiatrist and am writing in opposition to the proposal submitted by the HB-1771 that would create the new “Doctor of Medical Science Degree” and give physician assistants the authority to prescribe without physician oversight.
After completing rigorous graduate studies in anatomy, physiology, pathology and neuroscience, physicians go on to complete at least 10,000 hours of clinical training. No other health care professionals meet these standards. I personally completed a medical degree and greatly value my education. It was only my medical training, residency, and fellowship that prepared me to understand medications and safely prescribe them independently.

Please do not allow the state of Washington to fall victim to this dangerous proposal.

Erik Messamore, MD, PhD
Medical Director, Best Practices in Schizophrenia Treatment (BeST) Center
Associate Professor, Department of Psychiatry, Northeast Ohio Medical University

126. I am writing in opposition to the proposal of physician assistants practicing independently. They have less than half the training of licensed physicians. There is not substitute in physician training. PA provide a role in their own capacity and that should be maintained. Expanding them to independent practice will create substandard care for those they treat. It is confusing to patients. Physician oversight of PA should continue as is.

Dr Suwebatu Odunsi-Shiyanbade MD

127. I hope you are well. I am writing to you today to oppose Physician Assistant from independently practice in the state of Washington. With 4 years of Bachelor education and 2 years of both text book and hand-on medical education (master degree) is not enough to independently care for me or other patients. Most doctors have a total of 11 years to 17 years of education/training (after high school) before they could independently care for patients. I know of a case where a PA kept a patient in a psychiatric hospital for nearly 2 months because she was not sure about the treatment regiment and her medication dosing was suboptimal. Having proper medical knowledge will enable a provider to better help patients, either to influent the drug efficacy, to minimize side effects, drive the treatment course in the right direction, and minimize health care cost.

Telemedicine is uniquely suited to medicine and can solve the “access” problem these bills purported to solve.

Please let me know if you have any questions.

Victoria Ho

128. I am a psychiatrist and am writing in opposition to the proposal submitted by the HB-1771 that would create the new “Doctor of Medical Science Degree” and give physician assistants the authority to prescribe without physician oversight.

After completing rigorous graduate studies in anatomy, physiology, pathology and neuroscience, physicians go on to complete at least 10,000 hours of clinical training. No other health care professionals meet these standards. I personally completed a medical degree and greatly value my education. It was only my medical training, residency, and fellowship that prepared me to understand medications and safely prescribe them independently.

Please do not allow the state of Washington to fall victim to this dangerous proposal.

Elaine Martin, M.D.
I am an MD psychiatrist writing in opposition to the proposal submitted by HB-1771 that would create the new "Doctor of Medical Science Degree" and give physician assistants the authority to prescribe without physician oversight.

I have been the physician supervisor for multiple mid-level practitioners during my medical career, with varying levels of clinical experience (some having practiced only briefly, some for many years). I see a mid-level practitioner myself for part of my own personal medical care (women's health). Mid-level practitioners play an important and valuable role in allowing quality medical care to be provided efficiently to patients, WHEN THEY OPERATE WITH APPROPRIATE PHYSICIAN SUPERVISION and are not asked to perform beyond the scope of their training. Patients are ill-served, however, when this necessary level of physician collaboration is missing. As both a supervisor of mid-level practitioners AND AS A PATIENT SEEING THEM, I can speak strongly to the fact that additional didactic training short of medical school and residency training does not provide the scope of training necessary for safe INDEPENDENT medical practice. There have been multiple instances with all of the mid-level practitioners with whom I have worked (as well as the mid-level practitioner I see as my own provider) where the intervention of a physician's guidance has been necessary for safe and competent care.

After completing rigorous graduate studies in anatomy, physiology, pathology and neuroscience, physicians go on to complete at least 10,000 hours of clinical training. No other health care professionals meet these standards (nor would graduates of the proposed "Doctor of Medical Science" program). I personally completed a medical degree and rely daily on aspects of my medical training not obviously connected to my primary field of practice. The body is interconnected -- it is not possible to carve out a discreet area where the remainder of full medical training is not important and relevant. It was only my medical training that prepared me to understand medications and safely prescribe them independently.

It is important to remember that mid-level practitioners serve well as PHYSICIAN EXTENDERS (operating in collaboration with more highly trained physicians, who can direct or assume care when necessary). Mid-level practitioners are not, however, PHYSICIAN REPLACEMENTS.

Please do not allow the medical care of the citizens of Washington state to fall victim to this dangerous proposal.

Gillian Friedman, MD, Supervising Psychiatrist
San Jose Behavioral Health Hospital

I am writing as a concerned physician who was previously a physician assistant. The discussion to allow PAs to practice independently after completing the Doctor of Medical Science degree is deplorable. This is a matter of public safety. Time and time again, midlevel providers have demonstrated that they are not interested in serving in rural areas but instead are intent to be physicians without doing the necessary training. The data shows if. Even with the additional "training," PAs will still be ill-prepared to work independently of physicians. The differences in training for PAs and physicians is vast. You simply cannot know what you do not know until you go through extensive training. The proposed curriculum is, for lack of a better phrase, is not preparation for practice. They state their primary text will be MKSAP, a review text for the internal medicine boards, not even a primary text! Primary care is one of the most difficult specialties in medicine.

There is no mention of pediatrics. Children are NOT tiny adults. They have different and complex medical concerns. Even a seemingly healthy could have huge underlying pathophysiology missed by someone who is not a pediatrician.

Please protect Washington citizens. Offer them more. I hope you will reject this proposal.
Kelsey Childress, MD, Pediatrician

131. A graduating medical doctor with an MD or DO has completed 4 years of college and 4 years of medical school. The first two years of medical school are didactic (classroom and lab learning). The second two years are clinical (hands-on supervised learning in clinics and hospitals). During this journey, each graduate selects a field in which to specialize. Residency training can last from 3-8 years, depending on the specialty. A graduating resident has spent 12,000-16,000 hours at bedsides of patients. After 11-16 years of school and training, a physician is deemed competent to practice independently. Only top students are accepted into medical schools, ensuring that your physician will be smart.

Contrast this degree of education and training with physician assistants.

Physicians need to know how each organ system affects each other. Any medications or tests I prescribe happen after careful consideration of all comorbidities and possible side effects of therapies. I have witnessed firsthand the gaps in knowledge, misdiagnoses and incorrect treatments at the hands of non physicians. Since their education was not as detailed or extensive, they do not even know what they missed Patients taken care of by nonphysicians are overdugged, overradiated and overreferred, and there is data to prove this. Inappropriate use of medications comes with side effects and complications. Undiscerning use of referrals is expensive and may potentially subject one to unnecessary procedures. In the long run, these maneuvers only ramp up healthcare costs.

As a physician, I have pledged to "do no harm." It is my moral obligation to advocate for the sick and vulnerable, many of whom may not know the discrepancies in care witnessed by me and my physician colleagues. I urge you to oppose legislation that tries to allow non physician physician assistants the ability to practice independently. There certainly is a role for physician assistants in healthcare, but it is only as part of a team led and supervised closely by a physician. The good people of Washington deserve to be cared for by physicians, each of whom have dedicated their lives to this field and craft so as to practice within their respective scopes.

Thank you for taking the time to read this email

Beverly Ramos MD, Paso Robles, CA

132. I am a physician, Dr. Devinalini Misir, and I am writing to express my opposition to HB-1771, the bill that would create a new "Doctor of Medical Science" degree for physician assistants.

I am board certified in psychiatry. The process of becoming a psychiatrist involved four years of medical school, four years of General Psychiatry residency, and then a one year fellowship in a subspecialty of psychiatry. Even after so much training, I would never attempt to perform work outside of the scope of my specialty without the involvement of a physician who had specialized in that area of medicine. I think most people can easily see that it would be inappropriate for me, as a psychiatrist, to try to provide prenatal care to pregnant women without collaborating with an obstetrician, to give advice on heart disease without the involvement of a cardiologist, or to try to treat skin cancer without the expertise of a dermatologist.

Even though all physicians receive basic training in broad range of medical specialities, we recognize that the residency training that physicians undergo to specialize in one area of medicine is necessary to develop the knowledge base essential to provide excellent patient care. If a physician decides to switch from one specialty to another, they have to complete another residency, because there is no shortcut to obtaining this specialized knowledge. The training process of a physician is as long and rigorous as it is because it takes experience and a broad knowledge base to recognize the patients whose illnesses do not present in a classic textbook way, who require more investigation or a different approach to treatment.
That is why I do not feel it is appropriate for physician assistants to practice across different specialties of medicine without the oversight of a physician. Physician assistant training was never intended to allow them to do the work of a physician independently, but instead to work as part of a team with physician oversight. Giving PAs the ability to practice medicine independently destroys this team approach and pits physicians and PAs as competitors.

Additionally, I am concerned that creating a "doctor" degree for physician assistants will lead to confusion for patients. Just as we trust that someone who calls themselves a "lawyer" has specific knowledge and training that is demonstrated by completing law school and passing the bar exam, I feel it is important for patients to be able to trust that when they are dealing with a "doctor" in a medical setting, they are receiving care from someone who has undergone the rigorous training of medical school and residency that a physician has undergone. If patients discover that the "doctor" they are being seen by is someone who in fact has a much lower level of training, they may quite possibly feel deceived or lose trust in their healthcare team. I do not think that it is fair to place patients in that position when they are ill and vulnerable.

Devinalini Misir

133. I am writing you as a concerned physician practicing in Washington state regarding HB-1771 which intends to give physician assistants (PAs) full practice authority and create a new "Doctor of Medical Science Degree".

As a physician who has worked with PAs in multiple capacities, I cannot stress how dangerous this proposal is to patient safety. Though PAs serve a very important role in healthcare, they are not trained nor educated thoroughly enough to practice without physician oversight. To be objective, PAs have thousands of less clinical hours of training than a physician does after just one year of their residency and tens of thousands of less clinical hours of training than a physician does after completion of their residency (and all residencies are now a minimum of 3 years following completion of medical school). Besides hours of clinical training, the expectation of the training is completely different. Physicians are trained to become independent practitioners and accept full responsibility and liability; PAs are not trained in this way as their very name describes.

Secondly, establishing a degree whereby another "doctor" is created arbitrarily will further confused what is already a nebulous state in healthcare. Patients deserve to know what training and education their healthcare provider has immediately upon introduction.

I understand that PAs and their counterparts, nurse practitioners, are hoped to fill the physician shortage and provide care in rural areas, however, allowing these practitioners to practice independently with inadequate education and training is not the answer. I hope that you will make the right decision for patients of all walks of life regardless of where they live. Americans everywhere deserve better healthcare; they deserve physician led care.

Tejas Kirtane, MD

134. This bill HB-1771 is so controversial and talked about that it has reached us in the Midwest.

I am an Internist and Infectious Disease Specialist practicing in Ohio.

I am writing to oppose the proposed bill in your state that will allow Physician Assistants (PAs) to practice medicine independently. It is quite clear that Physician Assistants were named as such because they are not
substitutes or replacements for actual Physicians. This move to allow PAs to practice on their own is both dangerous and controversial. If given the choice today, I will continue to send my family members to Physicians rather than to midlevel providers for their medical care, unless the state and those vested in this bill can show proof that PA's training and expertise is similar to Physicians.

PA school and training is nowhere close to Medical school and training. The difference is vast. The maturity, knowledge base, clinical expertise, and dependability of a Physician comes with thousands of hours of learning cases, digesting information, and rigorous supervised training and certification. The run of the mill cases can be mixed with complex patients and one cannot certainly pick and chose who comes in through the clinic doors.

Allowing PAs to practice medicine independently who in my view have a subpar training in clinical medicine can have the following consequence:
1) missed and delayed diagnosis and potential harm to patients;
2) increase in testing, return visits, and referrals which will potentially delay diagnosis and increase reimbursement budgets and cost of healthcare;
3) potential for harm in prescribing medications to the outpatient baby boomer population who are quite complex;
4) difficulty in defining the limits and scope of practice of medicine once you give them a license to practice medicine independently and;
5) lowering the standards of medicine in the state of Washington and as a precedent in the country.

I beg you to review this bill thoroughly and weigh all the information at hand. Please avoid opening this can of worms.

Increase access to care does not always mean better quality of care. This is the same reason why the delivery of care is evolving from fee for service to quality measures. Can you assure quality when the the training, education, exposure, and certification of PAs is less than MD's/DO's.

Do the right thing and please stand for what is right for your community and your family.
Sincerely,

Dr Nelson Nicolasora

135. I'm not a Washingtonian, but I am a physician. I grew up in a small town in Arizona, where my father was the only surgeon. Growing up, he was frequently operating and making rounds in the hospital before I was even awake. It was not uncommon for him to join us in the middle of or after dinner. The risk of any family outing was that he would get called in to the hospital to operate. To this day, he still practices and operates. Remarkably, he still retained what he learned in his lectures and clinicals from medical school in the late-1960s.

I tell you this story not to showboat my father. Rather I am sharing this with you to elucidate what it means to be a physician. A "physician" is not merely a career choice, but a lifestyle, a persona and an identity. I have followed my father's footsteps into the noble field of medicine. I'm a practicing Internal Medicine physician in California.

A graduating medical doctor with an MD or DO has completed 4 years of college and 4 years of medical school. The first two years of medical school are didactic (classroom and lab learning). The second two years are clinical (hands-on supervised learning in clinics and hospitals). During this journey, each graduate selects a field in which to specialize. Residency training can last from 3-8 years, depending on the specialty. A graduating resident has spent 12,000-16,000 hours at bedsides of patients. Physicians like my father surpassed 16,000 hours because they worked in an era without work hour restrictions. After 11-16 years of school and training, a physician is deemed competent of independent practice. These
physicians go on to take certification and recertification exams to demonstrate sustained competency for the rest of their practicing lives.

Contrast this degree of education and training with physician assistants. They complete 4 years of college and 2 years of physician assistant school. A graduating physician assistant will have completed 500-1000 hours of training. They do not take certification and recertification exams.

How can 2 years of education with 1000 hours of training even compare as "equivalent" to 7-11 years of education with 16,000 hours of training?

In my field of Internal Medicine, I have to know how each organ system affects each other. Any medications or tests I prescribe happen after careful consideration of all comorbidities and possible side effects of therapies. I have worked at two of the top ten US News and World Report hospitals. I have witnessed firsthand the gaps in knowledge, misdiagnoses and incorrect treatments at the hands of midlevel practitioners, no matter the ranking of the hospital. Since their education was not as detailed or extensive, they do not even know what they missed.

Patients taken care of by midlevel practitioners are overdrugged, overradiated and overreferred, and there is data to prove this. Inappropriate use of medications and tests comes with side effects and complications. Undiscerning use of referrals is expensive and may potentially subject one to unnecessary procedures. In the long run, these maneuvers only ramp up healthcare costs.

As a physician, I have pledged to "do no harm." It is my moral obligation to advocate for the sick and vulnerable, many of whom may not know the discrepancies in care witnessed by me and my physician colleagues. I urge you to oppose legislation HB-1771, which attempts to allow physician assistants full independent authority. There certainly is a role for physician assistants in healthcare, but it is only when supervised and as part of a healthcare team. As Senator John McCain establishes his care at the Mayo Clinic, I can guarantee you that he will not be cared for by an "independent" physician assistant. The good people of Washington deserve the same access to high quality, cost-effective care by physicians who have dedicated their lives to this field and craft.

The larger question to ask is why we couldn't place 40,000 graduating medical doctors in the last five years into residency positions.

Thank you for taking the time to allow me to voice my concerns. I am happy to answer any questions and provide you with data about my stated concerns.

Uzma Khan, MD, Los Angeles, CA

136. I am writing to ask you to oppose the action that would approve the doctorate program that would lead to independent practice for PAs. I am not from Washington however I am a physician. As a physician I am one of the few who understand what PAs don't know. I am one of the few who understands how much learning is done in each step of physician training and knows that this program will still be missing a huge piece of training. As a physician I am one of the few who understands the determination, perseverance and dedication that it takes to be a physician, print others needs ahead of your own and your families. That personality is what the selection process for medical school is looking for. The selection process, the training regimen and depth, the residency are all crucial steps to helping prepare someone to have another life in their hands. There are already programs at medical schools that allow a shortened course for PAs to become physicians, already accounting for the training they have and filling in the gaps, that still leads to physician training including residency. Physician assistant is just that, a physicians assistant. That is what their training is geared to. It is not meant to be a shortened course to becoming a doctor. There is a shortage of doctors in the USA. The best way to fill that gap in to create more residency positions, not to create new pathways to become doctors. Your constituents, your family and loved ones deserve to have
the best trained personnel taking care of them. So does my family. We are on a slippery slope here. I urge you to consider this as you move forward. The lives of everyone around you is in your hands.

Julie Hicks, DO

137. I am writing in regards to the Doctor of Medical Science bill (WA) to express my strong opposition to the creation of a new profession which would allow physician assistants to be the "equivalent of physicians." As a member of the public who is well-informed of the vast difference in training who receives care from a primary care physician, I believe only physicians who have their MD or DO should practice medicine independently. There are other, far safer avenues to address the impending primary care shortage. This is a slippery slope which will only lead to PA independent practice which, to be frank, is unacceptable. This degree consists of a 1 year online curriculum using a board review text followed by 1 year of supervised practice. This is no where near what internists complete. You simply cannot know what you do not know. My fear is that primary care, which is one of the most complicated specialties, is being relegated to "just primary care." I hope this bill does not pass and that you will stand up to protect patients. For the safety of my family members living in the state, and all residents, please do not allow this legislation to pass.

Jacob McAuliffe

138. I am a resident physician studying dermatology and I would like to express my strong concern about Physician Assistants potentially gaining autonomy to practice without physician oversight.

As a dermatology resident, I train for 4 years, full time, to master my specialty. PAs train for less than 25% of this time.

If you look at Medicare reimbursement, you will see that PAs do a disproportionately high number of biopsies (11100) and furthermore have a significantly higher number needed to biopsy to catch malignancies.

Ultimately what matters is what is best for patients and the healthcare system as a whole and giving PAs practicing autonomy is dangerous to patients and costly to the healthcare system. PAs have a place in the healthcare system, just not as doctors.

Kelly Segars D.O., Resident Physician, PGY-3, Largo Medical Center Dermatology

139. Are you out of your minds? If you allow this law to pass, you must yourselves give up ever using a physician. PAs and ARNPs do not know what they don't know, and never will. A DMS is not an MD.

Barry Resnik, MD

140. I am writing in opposition of the bill that would allow physician assistants (PA) to practice autonomously without a supervising physician.

Physician assistants have a valuable role working as apart of a health care team with physician oversight. Physicians complete four years of medical school, followed by three years or more of medical residency, often followed by additional fellowship training.

PAs, on the other hand, complete less than two years of additional schooling following their undergraduate degree. It is exorbitant to believe that in less than two years of training, PAs are able to provide analogous care to that of a physician.
Patient safety would certainly suffer if PAs were able to treat patients outside of their scope of practice or without physician oversight. Although there is minimal available data, a study published in the 1999 Effective Clinical Practice journal showed that mid level providers (nurse practitioners) ordered more tests (imaging including ultrasounds, CT scans, MRI scans) than did their physician counterparts. Patients that saw a mid level provider also had worse outcomes with a greater percentage of patients referred to a specialist and a greater percentage of them requiring hospital admission. This supports the obvious assumption that less training leads to worse outcomes, negatively effecting patient safety and healthcare costs.

Carly Roman

Do not let PAs practice independently. PAs are assistants, not doctors.

Walter Wood, MD

141. After 17 years of post high school education I found myself worthy of being a doctor.

While physician assistants came as a result of corpmen with a skill set useful in surgery, they were never intended to function autonomously from the surgeon.

Allowing PAs the ability to practice medicine autonomously dilutes the meaning of being a doctor. The years of training required to become an expert. Studies have shown that PAs are more easily influenced by big pharma.

PAs should continue to help doctors extend their ability to treat by seeing routine follow ups and stable patients. Giving them an independent license will not result in more primary care. They will all label themselves as dermatologists and skin care experts.

Please focus on incentives to train physicians in this country, not on a way to reduce the quality of care.

Anthony Nuara MD PhD

142. The way to address physician shortages is by funding more residency spots and training more physicians, NOT by granting independent practice to nurse practitioners or physician assistants.

As a physician, I have seen myself the knowledge gaps in physician assistants and nurse practitioners. I would not trust my loved ones care to anyone but a trained MD or DO physician.

Here is a table comparing the difference in training and experience between physicians, nurse practitioners, and physician assistants (from http://midlevelu.com/blog/md-vs-np-vs-pa-heres-how-number-clinical-hours-compare a website actually promoting NP/PA).
Who do you want taking care of your family? Someone with half the years of training and 1/10 the number of clinical hours?

Let's keep Washington well with more physician training!

Megan Chiarelli, MD
143. I’m writing in reference to equal practice privileges for physician assistants with doctor of medical science degrees. I completely oppose any legislature that would effectively support that in any way. It is reckless and if the purpose is to grant more access to patients then I firmly recommend allowing more graduate medical education training spots for physicians to care for our citizens. It is unacceptable that midlevel practitioners are trying to equilibrate their training with physicians. Both NP and PA when they are used correctly in conjunction with a physician as an extender rather than in lieu of, excellent care will ensue. It is dangerous to allow inadequately trained practitioners to lead patient care. Furthermore, in states where NP were given equal practice rights to treat underserved they were not going to those areas and instead were competing with physicians in financially lucrative areas. Best care for yourself and families is expected to be done under expertise of highly trained professionals and we need to forbid the allowance of mediocrity when it is detrimental and dangerous. Allow me to bring to your attention that if an NP or PA cause direct harm to yourself or others there is no accountability and their malpractice though on the surface is there will not pay for your pain and suffering. A physician oath is First Do NO Harm and we self regulate and passionately care for our patients as oppose to passively watching others hurt them. I implore you to not let care crumble and people get injured or die because of lack of supervision by experts in the field of medicine...physicians that is. Medicine needs to return to physicians leading care and diagnosing/treating with assistance of midlevel providers as was intended to be. Who is your doctor? Would you want your child to be educated by a paraprofessional or a teacher. Respectfully, do you want someone with 7+ years of training, tens of thousands of hours of patient contact or one with 1-2 years of training for their field to lead your care and direct life and death decisions for you. Thank you for your consideration.

Abeer S. Griggs, D.O.

144. I don’t currently practice in the state of Washington but I am incredibly concerned about the potential to allow a short cut pathway for PAs to become equivalent to physicians. A 2 year degree after college and some additional schooling after that will never be equivalent to a 4 year post-graduate degree and then 3-8 years of extra residency training. This totally undermines the hard work, sacrifice, dedication, and value of the time a physician puts in to become a physician.

The PAs pushing for this will likely say that they will be filling the primary care need which will soon be found to be false as they pursue whatever specialty will give them the most income. This has become apparent as the National PA task force for autonomy has been very open about their goals which completely contradict what their initial stated purpose was to be a member of the physician-led health care team.

As it is, studies show that on average, a physician a day commits suicide. What a sad tragedy! I have a hard time believing how this average will not increase if such strides are made to allow PAs to get what they want.

Please, please think this through. PAs are definitely a valuable member of the health care team but they have not made the sacrifice or had the proper training to have autonomous rights.

R. Scott Thomas, DO

145. I'm writing to oppose HB-1771. I am a family practice physician, working in Vancouver, WA. I have supervised physician assistants in the past. I can confidently tell you that their medical knowledge, skill set and experience are no where near that of a physician. Their training is much less rigorous than ours, school entrance less competitive. It is dangerous to leave complex medical problems in the hands of someone who is untrained. I have witnessed first hand, if not supervised, the physician assistant would have made detrimental medical errors due to lack of experience and training. They are trained to assist
physicians, not to become one through legislations. Access should not be the reason to leave physician level responsibilities to midlevels. It is honestly unsafe.

I urge you to reject this bill.

Chau Le, DO

146. I am writing to discourage the current bill to grant Physician Assistants autonomous practice in Washington. The educational curriculum for Physician Assistants is not designed to prepare for autonomous practice and results in higher costs of care due to missed diagnoses, complications, and higher utilization of laboratory tests that would not be necessary with greater education.

Numerous studies have shown that allowing autonomous practice for mid level providers does not serve to increase access to care as mid level providers are drawn to the same major cities as Physicians. Allowing autonomous practice only serves to create a two-tiered healthcare system in which those with choice seek Physician care and those without will be forced to see the NP/PA their insurance participates with.

I understand the goals behind increasing autonomous practice, but medical school is designed the way it is to best prepare safe, effective medical care. This bill would only serve to undermine that responsibility.

Nate Miletta
August 8, 2017

Sherry Thomas
Policy Coordinator
Washington State Department of Health Sunrise Reviews
P.O. Box 47850 Olympia, WA 98504-7850

Via email to: sunrise@doh.wa.gov

Re: Washington Academy of Physician Assistants Comment on Doctor of Medical Science Sunrise Proposal

Dear Ms. Thomas,

The Washington Academy of Physician Assistants (WAPA) appreciates this opportunity to comment on the proposal to create a new health profession in Washington to license health care providers who have obtained a Doctorate of Medical Science (DMS) degree. WAPA strongly opposes the proposal to create a new health profession for DMS graduates because the proposal fails to meet the criteria defined in Washington’s Sunrise law RCW 18.120. Our comments will follow the structure of criteria laid out in RCW 18.120.010.

1. Unregulated practice by DMS graduates would not pose any threat to the health or safety of Washington’s patients.

Because every DMS graduate will have practiced as a licensed physician assistant (PA) for at least five years in primary care, the potential risk to the public of allowing these graduates to continue practice in primary care is minimal. PAs already practice in every area of medicine, potentially up to the full scope of their supervising physicians. RCW 18.71A.030; RCW 18.57A.030. Many PAs currently practicing in Washington have obtained further advanced education in psychology, education, public health and other fields and continued to practice medicine as PAs.

2. More cost-efficient alternatives to a new DMS license exist

A DMS license would not be self-sustaining. Creating a new licensed health profession involves costs for staff, rulemaking development, and ongoing regulatory activities. While most health professions (including PAs) are licensed in significant enough numbers to cover the cost of regulation through licensing fees, the few potential DMS applicants would be unable to cover the costs of regulating a new profession. Lincoln Memorial University in Tennessee began training DMS candidates in the fall of 2016. [https://www.lmunet.edu/academics/schools/debusk-college-of-osteopathic-medicine/dms/about](https://www.lmunet.edu/academics/schools/debusk-college-of-osteopathic-medicine/dms/about). When the first class of approximately 40 students graduates in 2018, there is no evidence that any of those graduates intend to practice in Washington. Even if every one of their graduates relocated from Appalachia to the Pacific Northwest, forty licensees would unlikely cover the cost of licensure and regulation.

Continuing to regulate DMS degree-holders under existing PA laws would be efficient and inexpensive. If a DMS diplomate chose to maintain their PA license and certification, it would cost the state nothing to allow DMS graduates to continue practicing as PAs, similar to PAs holding other
advanced degrees. This is the least restrictive alternative to creating a new licensing structure for DMS graduates.

3. The costs to society far outweigh any potential benefit of DMS licensure

Washington’s sunrise law requires an evaluation of potential costs and benefits of a new health profession. RCW 18.120.010(3). We believe the potential costs of the DMS proposal are significant:

The DMS degree sets a bad precedent in licensing a health profession without clinical training.

Students training to become nurses, nurse practitioners, physical and occupational therapists, psychologists, doctors, PAs, and countless other health professions must undergo clinical training, hands-on, with live patients, to assure students learn the standard of care from currently-licensed professionals participating in an accredited degree program. The DMS degree curriculum does not include any additional hands-on supervised practice necessary to increase health care providers’ clinical skills. The only reason this does not pose a risk to public safety is that all DMS students must be currently licensed PAs. Without clinical experience, the DMS degree is no different than the education and public health degrees many PAs already hold—valuable additional information, but nothing which alters their clinical preparation or skill level. Like PAs with other advanced degrees, DMS graduates should continue to practice as licensed PAs.

Lincoln Memorial’s DMS program does not adhere to any medical education accreditation standards.

While the Lincoln Memorial DMS program has received regional accreditation enabling students to obtain federal student loans, it remains unaccredited by the Accreditation Council for Graduate Medical Education, AOA Commission on Osteopathic College Accreditation or ARC-PA, graduate medical education accrediting organizations that assure the quality of curricula, faculty, and clinical experiences in MD, DO, and PA programs.

The Southern Association of Colleges and Schools accreditation standards include having a board of directors with legal authority, a CEO, a mission statement, a planning process, enrolled students, offering one or more degrees which meet minimum credit requirements, and having adequate faculty and library resources, student support services, physical facilities, and a quality enhancement plan. The Principles of Accreditation, Southern Association of Colleges and Schools Commission on Colleges (available here: http://www.sacscoc.org/pdf/2012PrinciplesOfAcreditation.pdf pages 13-21). None of these requirements affect the quality of medical curricula, faculty credentials, or other quality assurance requirements necessary to obtain accreditation for a physician or PA training program.

In contrast, to obtain ARC-PA accreditation, any PA program must be directed by a currently certified PA or licensed physician with board certification. Accreditation Standards for Physician Assistant Education, Fourth edition, Standard A2.06 page 22 (available online here: http://www.arc-pa.org/documents/AccredManual%204th%20edition%20May%202016%20FNL.pdf). The PA accreditation standards are exhaustive, and include specifications for adequate clinical training opportunities, supervised by appropriately credentialed preceptors, faculty credentials, curriculum standards, team-based practice standards and many more.

Without the oversight of a medical accrediting organization, the public has no protection from potentially unqualified faculty, curriculum gaps, or other possible deficiencies in the DMS degree
program. Allowing an unregulated degree program to prepare medical practitioners for licensure in Washington State would be a bad precedent to set.

**The DMS licensure proposal is bad for PAs.** PAs are already well-qualified medical practitioners providing high quality care across the full spectrum of medical specialties. The DMS degree will not meaningfully improve PAs qualifications to treat patients, since the “clinical component” consists of the PA continuing to practice in primary care as they have been for at least three years. PAs who study for the DMS degree may incur significant additional debt, and may require increased compensation to continue providing medical services to patients. Their increased salary requirements may make DMS graduates less competitive for employment when compared to PAs and nurse practitioners.

**The DMS licensure proposal is bad for employers.** It is hard to see why any employer would want an experienced practicing PA to take on the course load and financial burden to obtain a DMS degree when it does not provide training which would affect clinical competence and may increase the cost of future employment. Any practice currently employing a PA is getting the same value from that PA as they would if the PA obtained a DMS degree. For employers reluctant to hire PAs because of the regulatory burden of delegation agreements and supervision, the DMS requirement to submit evidence of institutional affiliation to the state as a condition of licensure is likely to pose an equivalent barrier to employing DMS licensees.

**The DMS licensure proposal is bad for patients, because it may increase costs and reduce professionals available in rural and underserved areas.** If any significant number of PAs were to obtain the DMS degree, their cost of providing care is likely to rise compared to their PA colleagues. The proponents of the DMS degree have suggested DMS licensees would bill at the physician rate, which is often higher than the PA rate for health care payers. Furthermore, the DMS graduates need for increased compensation is not a benefit to the public, and may make it harder for rural and underserved clinics to employ them. The cost of the DMS degree might incentivize PAs to leave underserved medical practices to seek higher salaries elsewhere.

To conclude, the Washington Academy of Physician Assistants urges the sunrise review panel to reject this request and find that the existence of the DMS degree does not justify the creation of a new health profession in Washington State. Thank you for the opportunity to comment.

Sincerely yours,

Connie Huynh PA-C

President, Washington Academy of Physician Assistants
August 9, 2017

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Sunrise Reviews
PO Box 47850
Olympia, WA 98504-7850

Re: Doctor of Medical Science Sunrise Review

Dear Ms. Thomas,

On behalf of the Washington State Medical Association and our more than 10,000 physician and physician assistant members from across the state, we are submitting comments on the Sunrise Review to create and regulate a new health profession, Doctor of Medical Science. We appreciate the opportunity to share our comments and look forward to working with you as the Department of Health considers this proposal.

The WSMA is strongly opposed to creating this new health profession and granting the licensees independent practice equivalent to physicians for the purpose of primary care. Our comment will outline the following concerns, in addition to other elements:

- Licensure of a DMS as a health care profession is unprecedented and could jeopardize patient safety due to inadequate training and education for independent practice.
- Access to care will not be improved as individuals who would potentially work under the DMS license are already treating patients as physician assistants with broad latitude under current Washington state law.
- The DMS designation will cause confusion for patients, who may think it confers a superior level of education and training to that of a physician.
- Applicants to the DMS program will incur significant costs, yield uncertain benefits and necessarily drive costs to the health care system.

Please see the analysis below supporting our position.

(1) Defining the problem and why regulation is necessary:

The applicant fails to demonstrate how the licensure and regulation of a new category of practitioners will solve the problem of access to care. While this question was among many the applicant did not answer in the Sunrise Review, supplementary materials note “…this program bridges the physician assistant (PA) to a new type of doctoral-trained provider to aid Appalachia and other health care shortage areas.”

Ensuring access to care is unquestionably a challenge in our state and across the country. However, the demographics, health care workforce, and regulations of Washington state are starkly different from those of Appalachia (which is repeatedly referenced throughout
The applicant fails to demonstrate why the proposal and subsequent regulation is necessary in Washington state.

The status of medical care in Washington state is quite different than that in Appalachia, and in Tennessee where Lincoln Memorial University is located. An example of workforce differences is provided in a report cited by the applicant. The 2015 State Physician Workforce Data Book by the Association of American Colleges ranks Tennessee as 34th in the nation for physicians per 100,000 population with less than 80. By contrast, Washington ranks 13th with more than 90 per 100,000. The same report details the drastically higher rates of stroke and heart disease in Tennessee than Washington. Tennessee has a workforce shortage much greater than Washington and greater prevalence of serious health conditions like stroke and heart disease, and therefore the needs of Tennessee are significantly different than those in Washington state.

Recognition of DMS as a regulated profession is unnecessary in Washington because Washington has been proactive in increasing the number of primary care and family practice residencies in our state, a much more effective and responsible way to increase work force.

Supplementary application materials claim the number of medical residencies has been capped by the federal government since 1997. While that is true of residencies funded federally through Medicare, Washington state has its own residency funding stream – focused exclusively on primary care – in the Family Medicine Residency Network. In the 2015 legislative session, the WSMA was successful in working with a broad coalition of stakeholders and lawmakers to substantially increase primary care residencies in the state. That funding was extended through 2021 in the most recent legislative session.

On the medical school level, the College of Osteopathic Medicine at the Pacific Northwest University of Health Sciences opened in 2008, accepting 70 students every year. And this year the Elson S. Floyd College of Medicine at Washington State University will welcome its first 60-student cohort. A goal of both the expansion of medical school slots and residency slots in the state was to address the need for access to care – particularly primary care in the state’s rural and underserved areas.

Telemedicine is another area where the state has recognized – and responded to – the need for improved access to care. Legislation in 2015 (built upon by subsequent bills in 2016 and 2017) required insurance coverage for care delivered via telemedicine, whether in a clinical setting or wherever a patient determines care is appropriate. In 2017 the state also approved legislation authorizing Washington to join the Interstate Medical Licensure Compact, facilitating the practice of medicine (and particularly telemedicine) across state lines.

Moreover, there is a distinct possibility that the DMS proposal, if successful, would not improve access to care. Applicants to the program are already licensed and working as physician assistants – many currently

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2 http://app.leg.wa.gov/billsummary?BillNumber=1485&Year=2015
3 http://www.pnwu.edu/inside-pnwu/about-pnwu/
4 https://medicine.wsu.edu/about/about-the-college/facts-figures/
5 http://app.leg.wa.gov/billsummary?BillNumber=5175&Year=2015
6 http://app.leg.wa.gov/billsummary?BillNumber=6519&Year=2015
7 http://app.leg.wa.gov/billsummary?BillNumber=5436&Year=2017
8 http://app.leg.wa.gov/billsummary?BillNumber=1337&Year=2017
helping to meet the need for primary care. A DMS would be treating patients much as a physician assistant is today given the latitude state law already allows.

Further steps should be taken to address the need for primary care and access to health care more generally in Washington state. But the problem of access to care is not solved by the DMS proposal. Continuing to build on recent gains around medical education, residencies, and health professional student loan repayment would be the more effective route.

1(a) The nature of the potential harm to the public if the health profession is not regulated, and the extent to which there is a threat to public health and safety.

This applicant fails to demonstrate how the public would not be harmed by the creation of this profession. Even if regulated, there is a substantial risk of harm to the public as a result of the DMS proposal. Given that licensure of a DMS is unprecedented, there is no indication that the level of training and education being proposed is appropriate or sufficient. More alarming is the suggestion by the applicants in the Sunrise Review that a DMS could be unregulated – a suggestion that fails to protect patient safety and is contrary to the Department of Health’s interest in regulating health professions to help assure quality care.

Applicants to the DMS program must have three years of experience as a supervised physician assistant, but it is not specified that the experience would be in a primary care setting. It’s also not specified that the supervising physician would have any special training to help prepare the applicant for independent practice.

This leaves the online education outlined in the Sunrise Review to prepare a DMS to independently practice primary care. This is particularly concerning given that the education would be the only completely-online curriculum in the country, and would be “framed from” rather than accredited by the standards of the American Council for Graduate Medical Education. Completing an unaccredited online course cannot possibly prepare an individual to independently diagnose and treat the panoply of conditions that a primary care provider will encounter. The uniquely rigorous training physicians complete teaches them to diagnose and treat a much wider range of medical conditions than other medical professionals.

1(b) The extent to which consumers need and will benefit from a method of regulation identifying competent practitioners, indicating typical employers, if any, of practitioners in the health profession.

The applicant fails to demonstrate how consumers need and will benefit from the regulation of a new category of practitioner. As previously stated, we disagree with the claim that patients will benefit by seeing greater access to care as a result of the creation of a DMS license. The proposal will not increase the net number of practitioners in the state, but more likely result in changing the credentials of existing providers. There is a distinct possibility that the DMS proposal, if successful, would not improve access to care.

Applicants to the program are already licensed and working as physician assistants – many helping to meet the need for primary care. A DMS would be treating patients much as a physician assistant is today given the latitude state law already allows. If anything, a physician assistant may have less time to treat patients while enrolled in the program, decreasing access to care during that time.
1(c) The extent of autonomy a practitioner has, as indicated by: (i) The extent to which the health profession calls for independent judgment and the extent of skill or experience required in making the independent judgment; and (ii) The extent to which practitioners are supervised;

The applicant fails to demonstrate that independent practice is appropriate, considering the extremely high level of education, skill, and experience needed to exercise independent judgement in the primary care setting. A DMS would have independent practice authority under this proposal. As previously stated, given that the licensure of this profession is unprecedented, there is no indication that the level of training and education being proposed is sufficient. This unprecedented profession could unnecessarily jeopardize patient safety without adding value to the state’s health care system.

Existing policy from the American Medical Association (AMA) is relevant here:

The AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state’s requirements for licensure to engage in the practice of medicine and surgery in all of its branches. [H-35.988]

(2) The efforts made to address the problem: (a) Voluntary efforts, if any, by members of the health profession to: (i) Establish a code of ethics; or (ii) Help resolve disputes between health practitioners and consumers; and (b) Recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem:

The applicant has failed to demonstrate through voluntary means or otherwise the intent or plan to develop any code of ethics. Every medical profession has a scope of practice and code of ethics. It appears that the applicants plan to defer to MQAC to develop a scope of practice, but there appears to be no plan to develop a code of ethics. These deficiencies are exemplary of a proposal that is not ready for meaningful consideration.

Additionally, while the applicants have made no alternative efforts to address the problem of access to care, as noted above there has been substantial progress made in telemedicine, medical education, residencies, and student loan repayment for health professionals. A recent Health Workforce Council Annual Report substantiates the gains that have been made in this regard.9

Further steps should be taken to address the need for primary care and access to health care more generally in Washington state. But the problem of access to care isn’t solved by the DMS proposal. Continuing to build on recent gains around medical education, residencies, and health professional student loan repayment would be the more effective and responsible route.

(3) The alternatives considered: (a) Voluntary efforts, if any, by members of the health profession to: (a) Regulation of business employers or practitioners rather than employee practitioners; (b) Regulation of the program or service rather than the individual practitioners; (c) Registration of all practitioners; (d) Certification of all practitioners; (e) Other alternatives; (f) Why the use of the alternatives specified in this subsection would not be adequate to protect the public interest; and (g) Why licensing would serve to protect the public interest.

See response to (2) above.

(4) The benefit to the public if regulation is granted.

Again, we disagree with the claim that patients will benefit by seeing greater access to care as a result of recommending licensure for graduates of a DMS program, as it would likely result in changing the credentials of existing providers, rather than adding to the state’s health care work force. There is a distinct possibility that the DMS proposal, if successful, would not markedly improve access to care.

Applicants to the program are already licensed and working as physician assistants – many currently helping to meet the need for primary care. A DMS would be treating patients much as a physician assistant is today given the latitude state law already allows. If anything, a physician assistant may have less time to treat patients while enrolled in the program, temporarily decreasing access to care.

(4)(a) The extent to which the incidence of specific problems present in the unregulated health profession can reasonably be expected to be reduced by regulation.

In their Sunrise Review, the applicants suggest that “The addition of this profession has the potential to increase the primary care workforce in the State of Washington by attracting DMS trained clinicians to the state…” This implies that the applicants believe it to be desirable that Washington would become a magnet state for DMS graduates – which would be a natural effect of whatever state becomes the first to recognize the profession.

Given the unprecedented nature of the proposal and the questions about whether the proposed DMS training and education would be sufficient, it is even more concerning that the applicants envision not only enrolling and ultimately licensing in-state physician assistants, but also Washington becoming a landing place for DMS graduates from other areas.

(4)(b) Whether the public can identify qualified practitioners.

The applicant fails to demonstrate how the public will be able to readily identify the difference in training, education, and expertise between a Medical Doctor and a Doctor of Medical Science. As noted by the applicants, there is already confusion about the use of the term “doctor” among the general public. Adding a new profession – the first of its kind in the United States – with the designation of Doctor of Medical Science will only exacerbate this problem. A layperson might even believe the term connotes a higher level of education and training than a medical doctor.

In the Sunrise Review, the applicants say it is “not the intent” that the term doctor would be used by a DMS without the use of the full term “Doctor of Medical Science” but it is notable that they do not require the utilization of the full term. If the proposal moves forward, it should be required that the applicants reidentify the license, selecting a designation that more clearly describes the training and education of would-be licensees.

(4)(c) The extent to which the public can be confident that qualified practitioners are competent.

Again, even if regulated, there is a substantial risk of harm to the public as a result of the DMS proposal. Given that DMS licensure is unprecedented, there is no indication that the level of training and education being proposed is sufficient.
Applicants to the DMS program must have three years of experience as a supervised physician assistant, but it is not specified that the experience would be in a primary care setting. It’s also not specified that the supervising physician would have any special training to help prepare the applicant for independent practice.

This leaves the online education outlined in the Sunrise Review to prepare a DMS to independently practice primary care, which is troubling given that the education would be “framed from” rather than accredited by the standards of the American Council for Graduate Medical Education. The uniquely rigorous training physicians complete teaches them to diagnose and treat a much wider range of medical conditions than other medical professionals.

(4)(c)(i) Whether the proposed regulatory entity would be a board composed of members of the profession and public members, or a state agency, or both, and, if appropriate, their respective responsibilities in administering the system of registration, certification, or licensure, including the composition of the board and the number of public members, if any; the powers and duties of the board or state agency regarding examinations and for cause evocation, suspension, and nonrenewal of registrations, certificates, or licenses; the promulgation of rules and canons of ethics; the conduct of inspections; the receipt of complaints and disciplinary action taken against practitioners; and how fees would be levied and collected to cover the expenses of administering and operating the regulatory system.

We have no comment on this section.

(4)(c)(ii) If there is a grandfather clause, whether such practitioners will be required to meet the prerequisite qualifications established by the regulatory entity at a later date.

We have no comment on this section.

(4)(c)(iii) The nature of the standards proposed for registration, certification, or licensure as compared with the standards of other jurisdictions.

We have no comment on the section.

(4)(c)(iv) Whether the regulatory entity would be authorized to enter into reciprocity agreements with other jurisdictions.

We have no comment on this section.

(4)(c)(v) The nature and duration of any training including, but not limited to, whether the training includes a substantial amount of supervised field experience; whether training programs exist in this state; if there will be an experience requirement; whether the experience must be acquired under a registered, certificated, or licensed practitioner; whether there are alternative routes of entry or methods of meeting the prerequisite qualifications; whether all applicants will be required to pass an examination; and, if an examination is required, by whom it will be developed and how the costs of development will be met.
As previously stated, there is a substantial risk of harm to the public if the DMS proposal is successful. Given that independent practice for physician assistants is unprecedented, there is no indication that the level of training and education being proposed is sufficient.

Applicants to the DMS program must have three years of experience as a supervised physician assistant, but it is not specified that the experience would be in a primary care setting. It’s also not specified that the supervising physician would have any special training to help prepare the applicant for independent practice.

This leaves the online education outlined in the Sunrise Review to prepare a DMS to independently practice primary care, which is troubling given that the education would be “framed from” rather than accredited by the standards of the American Council for Graduate Medical Education. Importantly, the DMS program specifically does not include supervised field experience and there is no DMS training program in Washington state.

**We have no comment on sections (4)(c)(vi) through (4) (d)(ii).**

**(5) The extent to which regulation might harm the public.**

As previously stated, we disagree with the claim that patients will benefit by seeing greater access to care as a result of the Sunrise Review as it would likely result in changing the credentials of existing providers, rather than adding to the state’s health care work force. Applicants to the program are already licensed and working as physician assistants – many helping to meet the need for primary care. A DMS would be treating patients much as a physician assistant is today given the latitude state law already allows. If anything, a physician assistant may have less ability to treat patients while enrolled in the program, decreasing access to care during that time. And given that the content and method of teaching is almost unprecedented in medical education, there is no certainty that DMS graduates will be able to practice medicine with reasonable skill and safety.

**(5)(ii) Whether the proposed legislation requires registered, certificated, or licensed practitioners in other jurisdictions who migrate to this state to qualify in the same manner as state applicants for registration, certification and licensure when the other jurisdiction has substantially equivalent requirements for registration, certification or licensure in this state; and (b) whether there are similar professions to that of the applicant group which should be included in, or portions of the applicant group which should be excluded from, the proposed legislation.**

As stated above, Washington would be the first state to license graduates of the DMS program. In their Sunrise Review the applicants suggest that “The addition of this profession has the potential to increase the primary care workforce in the State of Washington by attracting DMS trained clinicians to the state…” This implies that the applicants believe it to be desirable that Washington would become a magnet state for DMS graduates – which would be a natural effect of whatever state becomes the first to recognize the profession.

Given the unprecedented nature of the proposal and the questions about whether the proposed DMS training and education would be sufficient, it is even more concerning that the applicants envision not only enrolling and ultimately licensing in-state physician assistants, but also Washington becoming a landing place for graduates from other areas.
The maintenance of standards: Whether effective quality assurance standards exist in the health profession, such as legal requirements associated with specific programs that define or enforce standards, or a code of ethics; and How the proposed legislation will ensure quality; The extent to which a code of ethics, if any, will be adopted; and the grounds for suspension or revocation of registration, certification, or licensure.

Since the DMS program is new, and offered only by one college in the United States, there are no quality assurance standards or ethical standards for the DMS profession. Any proposed legislation will not be able to mandate the curriculum or academic requirements of the DMS training program since it is not under the jurisdiction of Washington state.

The expected costs of regulation: The impact registration, certification or licensure will have on the costs of the services to the public; The cost to the state and to the general public of implementing the proposed legislation.

If adopted, the creation of a DMS license will necessarily incur significant costs to the Medical Quality Assurance Commission (assuming a DMS will be a regulated profession), the would-be licensees and the general public – without guaranteeing a meaningful return on investment to any party.

Significant costs to MQAC and the state will be driven in the form of creating, approving and administering exams, as well as regulating the would-be licensees. MQAC has consistently been underfunded by the state in recent years, and this year’s state operating budget finally made needed investments in staff and other support. Adding this budgetary pressure to MQAC would presumably put them back in the position of petitioning the Legislature for additional funding – a request that may not be well received in light of the investments made this year.

As detailed more fully in our response to 8(c), would-be licensees would face significant costs in the form of tuition to the online university, licensing costs, and medical malpractice insurance. As we have seen with many licensed professions with a small number of licensees, it can be expensive for the program to be self-sustaining – yielding high costs on a per-license basis. It is foreseeable that a DMS license would be considerably costlier than that of a physician assistant or even a physician.

Finally, all of these costs would ultimately be borne by patients. There is no other way for a DMS to recoup those costs than seeing more patients (which may result in less time per-patient) and/or charging higher rates. Given the fact that physician assistants currently have broad latitude to practice under the license of a physician, there is no discernable value being added for patients in return for these increased costs.

The cost to the state and the members of the group proposed for regulation for the required education, including projected tuition and expenses and expected increases in training programs, staffing and enrollments at state training institutions.

While the value conferred by a DMS license would be at best uncertain, the costs associated with it are very real. At $50,000 in projected tuition alone, a DMS would be taking on a large amount of debt for the ability to perform the same basic functions of patient care that s/he already does today. Additionally, a DMS may face increased licensure and medical malpractice costs that could be unforeseen to a prospective enrollee.
A recent Forbes article referred to student debt as “A $1.3 billion crisis.” In recent years this has been driven in no small part by the rise of online colleges, which tend to be more expensive than traditional colleges, have lower graduation rates, and lead to less-certain job prospects for graduates. That’s not to speak of the high-profile collapses of online schools such as Trump University, Corinthian Colleges and ITT Technical Institute. In 2016, the Washington State Legislature recognized the need for better state oversight and student protections around online schools, convening a study to make recommendations to inform future legislation.

While the high cost of enrolling in a DMS program will hopefully be transparent to prospective students, there are other costs that would be associated with the license that may not be apparent. As previously noted, it can be expensive and difficult to maintain a profession with a small number of licensees – it’s foreseeable that a DMS license would be more expensive to maintain than the license of a physician assistant or a physician. We have also been provided information from a medical malpractice company operating in the state who indicated that a DMS would likely be rated the same as a physician for the purpose of malpractice premiums – resulting in a drastic increase in premium rates for the DMS over what s/he paid as a physician assistant.

It is for these reasons that the WSMA is strongly opposed to creating this new health profession. Thank you for the opportunity to share our concerns. If you have any questions, please feel free to contact Kathryn Kolan at kak@wsma.org or Denny Maher at dpm@wsma.org.

Sincerely,

Denny Maher, MD, JD
General Counsel and Director of Legal Affairs

Kathryn Kolan, JD
Director of Legislative and Regulatory Affairs

cc: Jennifer Hanscom, Executive Director/CEO
WSMA Executive Committee

11 http://www.newyorker.com/magazine/2015/11/02/the-rise-and-fall-of-for-profit-schools
13 http://college.usatoday.com/2016/03/25/former-corinthian-colleges-to-pay-over-1b-for-defrauding-students/
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15 http://www.wsac.wa.gov/profit-schools-study
Memorandum
To: Sherry Thomas, Policy Coordinator, Department of Health Sunrise Reviews
sunrise@doh.wa.gov
From: Dr. Tony Kim, President, Washington State Podiatric Medical Association
tdhkdpm@msn.com
Re: Doctor of Medical Science (HB 1771) Sunrise Proposal
Date: August 7, 2017

The following comments are submitted on behalf of the Washington State Podiatric Medical Association (WSPMA), a statewide association representing podiatric physicians and surgeons. WSPMA appreciates the opportunity to comment on the sunrise review of proposed legislation (HB 1771) to create a new health care profession titled “Doctor of Medical Science” (DMS).

WSPMA opposes creation of this new profession. In making this statement, WSPMA wants to affirm its recognition and support for the important role that physician assistants (PAs) have in our health care delivery system. Many podiatric physicians work in multi-disciplinary practices with MDs, DOs, and PAs, and see evidence of this on a daily basis.

In developing our comments, WSPMA had the opportunity to review comments that are being submitted by WSMA and WAPA. Both sets of comments are extensive, and while there are some substantive differences, each make compelling arguments as to why creating a new health care profession for Doctors of Medical Science does not make sense for Washington State.

In our comments, WSPMA would like to highlight several key points:

- The purported rationale for creating the DMS profession is to increase access to primary health care services. The applicant report is full of comments concerning Appalachia, and the challenges in health care delivery in Tennessee. WSMA’s comments are excellent in pointing out that Washington is not Tennessee, and that in Washington we are currently employing many strategies to increase access to primary care.

- Creating a new DMS profession is not in the best interests of PAs. When the profession that a scope expansion proposal purports to help, opposes it, it speaks volumes. We affirm WAPA’s comments in this regard.

- Creation of a DMS profession will cause considerable confusion among the public.

In summary, we are aware of no rationale that would support establishing a DMS profession in Washington State. We therefore respectfully ask the Department of Health to reject this sunrise application.
August 8, 2017

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Sunrise Review
PO Box 47850
Olympia, WA 98504-7850

RE: Doctor of Medical Science Sunrise Review
Dear Ms. Thomas,

On behalf of the Washington State Chiropractic Association and the 2400 chiropractors practicing in Washington State, we provide you with the following comment regarding the Sunrise Review application proposing a new health profession, Doctor of Medical Science (DMS) degree.

The WSCA is opposed to this new profession and finds that the State of Washington already has the resources within its healthcare community to expand greater access to primary care options without the creation of a new profession. We concur with the public comment provided by the Washington State Medical Association (WSMA) and wish to raise additional concerns specific to our own organization.

With all due respect, the WSCA feels that the application from Lincoln Memorial University appears to be self-serving given they are the only educational institution offering a program that would meet the terms of the proposed DMS requirements.

It is our opinion that Washington State would be better served by initiating programs with already licensed health professionals who are fully functioning in an unsupervised role within existing health care delivery models. Such providers, including chiropractors, already have full diagnostic, triage, and case management experience directly pertaining to the most common patient presentations for care (musculoskeletal). Expanding the pool of existing providers, especially in rural areas where access to primary care is limited, better aligns with the best care practices for patients. In addition, chiropractors are already established in practice in 36 of the 39 counties in Washington State. Lincoln Memorial University references on page 15 of this application that “12 of the 54 MUA/MUP designations [in Washington] are entire counties.” Yet, while relying upon this fact, the application does not suggest placing the proposed DMS providers in those underserved communities. The purpose of primary care is not expecting that the Primary Care Physician (PCP) would treat every condition that enters their office. Rather, the provider is expected to perform a differential diagnosis, treat what they are able to, and triage and refer for those conditions they are unable to address in the primary care office. We believe that Washington State already has resources available to them to expand patient access to primary care without jeopardizing patient safety. Adding a health profession without considering the use of existing providers to relieve the primary care burden is unnecessary.
With regard to the specific regulatory factors addressed in the application, we raise the following issues:

1(a) The nature of the potential harm to the public if the health profession is not regulated, and the extent to which there is a threat to public health and safety. And,

1(b) The extent to which consumers need and will benefit from a method of regulation identifying competent practitioners, indicating typical employers, if any, of practitioners in the health profession. And,

1(c) The extent of autonomy a practitioner has, as indicated by: (i) The extent to which the health profession calls for independent judgment and the extent of skill or experience required in making the independent judgment; and (ii) The extent to which practitioners are supervised;

The proposal notes that the DMS emphasizes primary care, and that the new credential may “only practice primary care” (Proposal section (1) (b)(c)(i)(ii)). However, there is no accepted working definition for their role, or barrier for what constitutes the limitation of primary care practice, and what does not. In the preceding section, the proposal notes that the DMS professionals will be “evaluating potentially serious conditions” which raises an additional concern about what constitutes the limits of primary care. Unless, and until, the limitations of primary care are operationally defined, especially since the proposed DMS providers will be using “independent judgment” (section (1)(b)(c)(i)(ii)), the training or practice of DMS cannot be considered safe. There are no assurances to practice limitations without specific limiting definitions. And finally, without a scope of practice, the consumer cannot differentiate between this new credential and those already existing in statute.

The applicant further reports that the DMS “will not require specific mentorship or supervision” and that their training will be “demonstrated by either maintenance of hospital credentials, partnership in group practice, or letters of support from collaborating physicians.” If this is the extent of the criteria expected, it is woefully inadequate. Lastly, wherein the Sunrise application asks the extent to which consumers benefit from regulations identifying competent practitioners, indicating typical employers, etc., the applicant fails to answer.

(2) The efforts made to address the problem: (a) Voluntary efforts, if any, by members of the health profession to: (i) Establish a code of ethics; or (ii) Help resolve disputes between health practitioners and consumers; and (b) Recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem:

(3) The alternatives considered: (a) Voluntary efforts, if any, by members of the health profession to: (a) Regulation of business employers or practitioners rather than employee practitioners; (b) Regulation of the program or service rather than the individual practitioners; (c) Registration of all practitioners; (d) Certification of all practitioners; (e) Other alternatives; (f) Why the use of the alternatives specified in this subsection would not be adequate to protect the public interest; and (g) Why licensing would serve to protect the public interest.

Items 2 and 3 of the applicant proposal have gone unanswered, and worse, are asserted as “not pertinent to a DMS practice.” In complete agreement with the WSMA comment to this
section of the application, the WSCA would also add that more collaborative practice behaviors and integration of all health professions in managing conditions that present in the primary care providers office, is a more effective approach and could have an even greater effect on other policy matters when patients are given non-drug options.

(4)(a) The extent to which the incidence of specific problems present in the unregulated health profession can reasonably be expected to be reduced by regulation.
(4)(b) Whether the public can identify qualified practitioners.

This issue, along with our first comment referencing existing options to address the PCP shortage, could be the most troubling aspect of this application. The proposed title of this provider is beyond confusing, “Doctor of Medical Science.” The title itself suggests that the practitioner is an academic and not a clinician. It also potentially implies that other healthcare professions are not based upon science. As there is no definition for the DMS, or a scope of its practice, these questions remain unanswered.
(4)(c) The extent to which the public can be confident that qualified practitioners are competent.

The fact that this program is largely online means that, if application is granted, it could be the only health profession that has a significant portion of their education based solely online. Most of the health profession statute and rules limit the number of continuing education hours allowed by online access, yet this proposal focuses the base education on an online model, which is unprecedented.

We appreciate the opportunity to make public comment on this Sunrise application.

Sincerely,

Lori L. Grassi
Executive Director

cc: Shawn Gay, DC, President
    WSCA Executive Committee