The American Board of Physician Assistant Practice: As Remembered by William Stanhope and Carl E. Fasser

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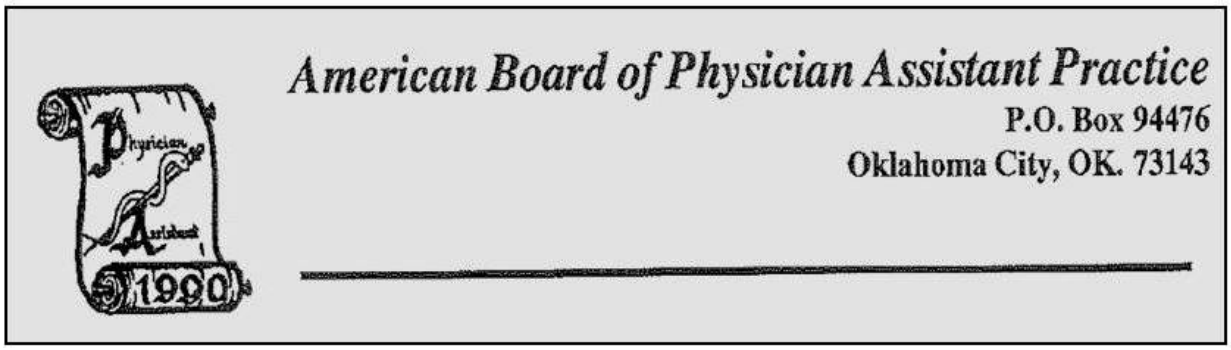


Introduction

Although each National PA Organization - American Academy of Physician Assistants (AAPA), Physician Assistant Education Association (PAEA), Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) and National Commission on Certification of Physician Assistants (NCCPA) – has their own distinct areas of responsibility, they all share in common the desire for PAs to be well-educated, competent heath care providers and life-long learners. This desire was shared by another PA organization that few PAs know about: the American Board of Physician Assistant Practice (ABPAP). The story of the ABPAP is indicative of the struggles and challenges faced by the PA profession during its third decade of existence, especially as more PAs chose to work in medical and surgical disciplines. The effectiveness of a single written examination focused on primary care and general medicine was a source of discontent amoung PAs working in specialties. Studies increasingly showed that traditional methods (e.g., passive lectures) used to provide continuing medical education (CME) to maintain evolving specialty competence was not working. Was there a better way to provide PAs the knowledge and skills that were germane to their particular practice setting and specialty? Those who established the ABPAP thought so and devised a systematic approach that was innovative for its time. But like many startup organizations, the ABPAP ran into unforeseen issues that had nothing to do with their approach per se, but more with intraprofessional polity. ABPAP's failure provides a valuable lesson learned only by those who attempt to create a new way of doing things. As such, failure is not a bad thing, but something that one can learn from.

Disclamier: Drawing on the recollections of two of the original members of ABPAP, this article details the history of the founding of ABPAP, its brief period of activity, and the authors' views of the factors that led to its failure.

Founding of the Organization

The ABPAP was established in 1990 to "promote the provision of quality care services by physician assistants through a structured approach to life-long learning which focuses on individual practice characteristics and learning styles."[1] The ABPAP recognized the entry-level examination developed by

the National Board of Medical Examiners on behalf of the NCCPA and the requirement for continuing medical education to maintain certification as necessary to practice as a physician assistant. The ABPAP planned to offer educational programs designed to interface with existing requirements by states to work as a physician assistant. The ABPAP Competency Assurance Program was voluntary and tailored to be flexible and capable of accommodating individual practice patterns and learning styles.[1]

According to state records, incorporation papers were filed on January 18, 1990 to establish the American Board Of Physician Assistant Practice, Inc. as an Oklahoma Domestic Not For-Profit Corporation. Roger Whittaker was listed as the Incorporator and Dan P. Fox as the Registered Agent of the corporation.[2] Both were previous presidents of the AAPA, Whittaker in 1976-77 and Fox 1977-78, and both were clinicians; Whittaker ran a hypertension clinic and Fox worked in occupational medicine.

Two photographs* of the first organizational meeting of the ABPAP were taken in 1990 in Oklahoma City. The one shown here was taken by Jeffrey Heinrich (see insert) and shows Carl Fasser, Roger Whittaker, Carl Williams, Linda Reed and Roger Elliott on the front row and Bill Stanhope, Thomas Godkins, Dianna Denton, Gary Sharp, Dan Fox and Jesse Edwards on the back row. At the time, Fox, Godkins, Deaton, Sharpe, Elliott, Reed, Williams and Whittaker were affiliated with the Oklahoma University PA program; Fox as program director and Sharp as associate program director. Those attending the organizational meeting worked clinically in a varity of specialties including ENT, industrial hygiene, occupational medicine, nephrology, and cardiology. Stanhope, founder of the Oklahoma University PA Program, was at the time chief of the Harlem PA program; Edwards was on the University of Nebraska PA program faculty; Fasser was PA program director at the Baylor College of Medicine, Houston TX and Heinrich was working in the Burn Unit at the Yale Trauma/Section of Plastic Surgery at Yale University.

Rationale for Establishing the ABPAP

The 1980s were marked by the public's growing expectation of visible evidence of provider continued competence. Also, classical CME and certifying exams were no longer viewed as a sufficient approach to continued professional development and for the documentation of continued competence. These concerns were written into a Health Resources and Services Administration (HRSA) contract to the AAPA (Willis J., et al, 1986) dealing with the PA role verification. As part of the grant, AAPA subcontracted to Ohio State (Ayers DeCosta, PhD) to develop a Self-Assessment Examination (SAE) that incorporated a process for computer-based feedback. An outgrowth of the SAE administration to PAs in clinical practice was the identification of areas of knowledge weakness along with the development of self-paced learning materials and actual four-week clinical practices experiences designed to shore up clinical skills. The clinical experiences were provided by the Baylor PA program in Houston. Judith Willis,

at the time AAPA's Director of Research, and Carl Fasser were very closely involved in the design and implementation of this aspect of the grant.

These experiences affirmed that it was possible to develop, administer, review performance, generate meaningful feedback and provide learning experiences targeted to the needs of specific PAs. As the idea of ABPAP was birthed, these experiences were reviewed along with an extensive literature review and synthesis completed by Linda Reed for her graduate program in education and the work of Dan Fox (not Fox in Oklahoma) on the antibiotic practices of physicians in Canada. Fox's conclusion was that despite academic detailing of physicians about appropriate prescribing practices, their behaviors did not change. Clearly, CME presented as passive lectures was not enough. (E. Carl Fasser, personal communication, June 30, 2020).

Together, the question was raised as to how better to ensure the continued competence of PAs and address the limits of the current continued competence system put forth by the NCCPA. Critical reflection of past and recent experiences at the time led to the design of the ABPAP's quality assurance program. Those establishing the ABPAP wanted to set up a system that would facilitate the obtainment of knowledge and skills needed for PAs to function effectively in a variety of clinical and surgical disciplines. They believed that no matter what type of specialty PAs worked in, there were some skill sets germane to the practice; core knowledge in that discipline that one absolutely needed to know. They viewed the traditional CME offered at regional and national PA meetings as not helpful to PAs working in specialties or those transitioning from one specialty to another. To keep abreast of new developments, the ABPAP felt that PAs would be better served by attending CME conferences sponsored by their physician specalists' organizations. ABPAP envisioned a model system that would assist and support the transition of (1) new PA generalist-trained graduates into specialty practice, (2) PAs who desired to move from one medical or surgical discipline to another and (3) provide meaningful educational CME activities and experiences relevant to one's specialty area of practice.

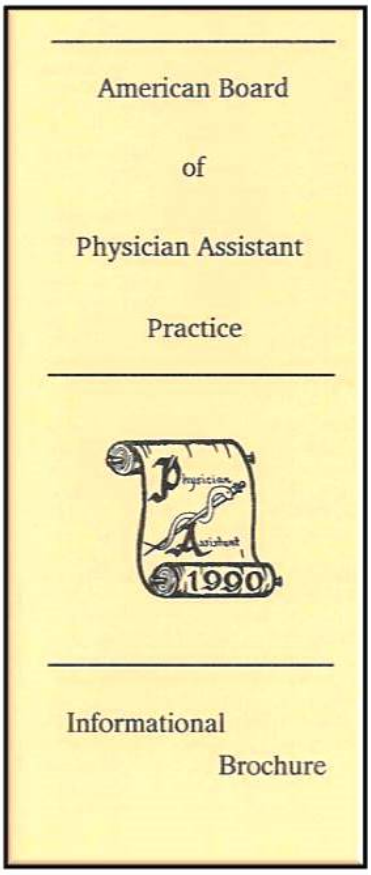
Methodolgy to be Used

The basic strategy to be used was to (1) determine core knowledge and skills required in each specialty, (2) develop an examination based on this core knowledge, (3) test and provide feedback about areas of weakness or competence, (4) provide self-administered learning study guides and self-directed learning strategies to correct deficiencies and (5) evaluate to determine if this approach improved practice behaviors. Plans were to log what PAs were seeing in their practices and use this information to develop examinations based on their scope of practice. It was envisioned that the AAPA constituent specialty groups would help with identifying the core knowledge and skills relevant to their discipline and beta test the examination and study-guides being prepared.

As customary in those days, much of the work would be done by volunteers. Reed and Fox at Oklahoma would conduct an extensive review of the literature around the effectiveness of current CME pracices. Fasser at Baylor and Fox at Oklahoma would provide internal funding to cover operational cost. Edwards would use the computer-based testing platform

(Mr. TIB) developed at Nebraska to help the ABPAP develop its examinations and provide feedback to examinees. Informational brochures were printed and distributed to AAPA constituent specialty groups and a newsletter, the *PA Monitor*, was published to keep these groups informed of the ABPAP's progress. Two specialty groups, occupational medicine PAs and cardiovascular PAs, decided to join the ABPAP in its mission. The cardiovascular PAs were already working on an examination and liked the idea of providing feedback regarding how one tested compared to peers and the use of study guides to help address areas of deficiencies. So the ABPAP was on track to put their plans in action. What happened next?

ABPAP Derailed



ABPAP's mission and goals were being publicized and a couple of PA specialist organizations were showing interest but were waiting to see how things went. The organization was garnering significant interest among specialty groups, and the AAPA Board of Directors invited representatives from the ABPAP to give them a presentation. The AAPA leadership was apprehensive about establishing an alternative approach that some states might adopt rather than the NCCPA recertification process which they endorsed (W. Stanhope, personal communication, June 18, 2020). Those presenting for the ABPAP were all past presidents of the AAPA who, in the organization's formative years, were used to exploring and adapting new ideas. No one on the current AAPA Board could tell the ABPAP what was wrong about their suggested evidenced and educational approach to providing CME that improved PAs' individual practices. The AAPA leadership's concerns seemed by ABPAP's leadership to be more political then academic. By the end of the presentation, it became clear that the AAPA leadership was going to oppose the evolution of the ABPAP's approach. At the time, the ABPAP representatives believed that the acceptance of their CME process by state licensure boards was a secondary matter. Each of the ABPAP presenters had extensive firsthand experience in dealing with regulatory agencies and the legislative process and were convinced that any related concerns could be overcome as the need arose. Given the pressing needs to ease states' restrictive practice rules and regulations, to enact prescriptive privileges and to gain Medicare reimbursement, there were too many competing priorities to deal with at the time.

Epilogue

Without AAPA support, the ABPAP leadership knew it would be impossible to get AAPA constituent specialty groups involved in helping develop, manage and evaluate the ABPAP CME systems approach. Subsequently, Dan Fox stepped down as program director at Oklahoma, and Bill Stanhope left his directorship at Harlem to head a spinal program at Montefiore Medical Center in the Department of Neurosurgery. Access to internal PA program funding was no longer available, and others involved in

the ABPAP had growing obligations. So the ABPAP leadership decided to just let the organization "lie fallow" (W. Stanhope, personal communication, June 18, 2020). The organization was not dissolved and according to the Oklahoma Secretary of State, remains in active status to this day. [2]

Looking back, it appears that the ABPAP's mission and goals were 20 years ahead of their time. The struggle to obtain legislative approval of PA practice in each state was ongoing. Much work and effort had gone into having states recognize the NCCPA's recertification process that included an examination and mandatory CME requirements. At the time, supporting the ongoing recertification process being advocated by the AAPA and NCCPA was more important than trying to develop an alternative CME process.

Over time, circumstances have changed and many of the goals of the ABPAP have been and are being adopted, especially by the NCCPA. In 1992, the AAPA and NCCPA formed a partnership to develop an alternate mechanism for PA recertification known as Pathway II which consisted of a take-home examination plus an elective component. In 1997, the NCCPA redesigned its national certifying examination (PANCE) and separated out a new "stand-alone" examination that allowed PAs to earn "special recognition" in surgery. In 2011, the NCCPA launched its Certificate of Added Qualifications (CAQ) program for certified physician assistants (PAs) practicing in Cardiovascular and Thoracic Surgery, Emergency Medicine, Nephrology, Orthopaedic Surgery, and Psychiatry. In 2016, two additional CAQ's were launched in Pediatrics and Hospital Medicine. In 2019, NCCPA refined the blueprint for their recertification exam (PANRE) to reflect core medical knowledge and skills and launched a pilot of an innovative online longitudinal assessment designed to help PAs address knowledge gaps. Today, the NCCPA continues to examine assessment and certification maintainance strategies that meet the evolving needs of its diverse stakeholder groups, including PAs working in speciality and primary care disciplines.

The history of the ABPAP provides us a valuable lesson. Maintaining intraprofessional harmony is a worthy goal for PA leaders, but that should not deter the positive exchange of innovative ideas nor stiffle meaningful dialog. PA professional leaders have to be visionaries who remain committed to doing what is best to assure the public that PAs are up-to-date and highly qualified to do what they do in the settings and specialties in which they work. As a flexible workforce, PAs need to have a process that can help them change specialties more easily and that assures standards of quality are being met. Innovation and systemic change remain important drivers for the PA profession's success.

References:

1. American Board of Physician Assistant Practice. (1990) Mission Statement and Goals. (Unpublished Manuscript) Compency Assurance Program for Physician Assistants.
2. Oklahoma Secretary of State. American Board of Physician Assistance Practice. (1990) Entity Summary Information. Available at https://www.sos.ok.gov/corp/corpInformation.aspx?id=2100486161 . Accessed June 3, 2020.

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