

Clinical Doctoral Degrees—Are We Ready?

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Our profession is maturing. Like our physician counterparts, physician assistants (PAs) work and train in many specialty areas of medicine. Formal fellowships, or residency programs, for PAs have existed for some time in a variety of specialties. It seems logical, and even inevitable, that these programs mature in parallel with our profession and those of other nonphysician health care providers. I believe it is time for us to configure our fellowships to award doctoral degrees to graduates. This would enable us to recognize the advanced education of these PAs, advance our profession, and enhance our competitiveness in the marketplace.

Many other nonphysician health care professions have already done this. Examples of nonphysician providers who can earn clinical, professional doctoral degrees in their disciplines are physical therapists (DPT and DScPT), psychologists, (PsyD), optometrists (OD), pharmacists (PharmD), audiologists (AuD), chiropractors (DC), and podiatrists (DPM).

Doctoral degrees for PAs could be uniformly awarded as, “doctor of science in [insert specialty].” So, for an emergency medicine PA the degree would read, “doctor of science in emergency medicine,” and would be abbreviated as, “DScEM PA-C.” These degrees would not be PhDs and would therefore carry a different standard and expectation. They would recognize the advanced knowledge, training, and capabilities of the holder and, unlike a PhD, which focuses on research and teaching, would be specifically designed to improve the delivery of patient care by their holders.

Undoubtedly, if we accept the challenge of granting doctoral degrees for postgraduate programs, these programs will require modifications to meet the more vigorous requirements of a doctorate. I would like to first review some facts and assumptions.

These are the facts as I see them:

- PAs are physician extenders that work in virtually every specialty area of medicine.
- The PA profession is modeled after the medical profession and is more or less following its historical trajectory.

- The entry-level degree for PA training is rapidly moving toward the master’s degree.
- There are already a number of formal postgraduate specialty training programs for PAs in existence.

These are my assumptions:

- The PA profession will continue to develop and grow along a path similar to that taken by physicians after World War II, when we saw the rapid emergence of residency and specialty training.
- PAs will eventually be able to acquire formal, postgraduate training in a wide variety of specialty areas.
- PAs will continue to develop professional societies in a wide variety of specialties, such as the Society of Emergency Medicine PAs.
- Postgraduate specialty programs will become standardized and produce nationally recognized advanced training certification, which will take the form of a doctoral degree.
- Eventually, nearly all PAs will receive postgraduate training as either generalists or in a specialty, much the same as physicians do.
- Postgraduate training will become more proportional to the equivalent physician specialty. PA school is half the length of medical school, so logically specialty PA training should be half the length of physician residency or fellowship training for a given specialty.
- Ultimately, doctorally trained PAs will occupy an intermediate training level while some PAs will go further to complete fellowships in subspecialties as part of a continuing effort to become exceptionally competent physician extenders for all physicians in all specialties.

- PAs will always continue their role as physician extenders—just as better ones.

There are many good reasons to create a professional doctoral program for PAs, and some reasons not to. Here are the pros and cons as I see them:

Pros

1. A doctoral degree acknowledges the rigorous academic training and advanced clinical skills possessed by graduates of qualified programs.
2. Many PA schools award a master's degree; hence, a higher (doctoral) degree for advanced training is logical.
3. Graduates would be able to deliver improved patient care and be prepared for the most demanding jobs in their area of expertise.
4. Graduates will stay competitive with nurse practitioners, who are planning to implement doctoral training soon, and with other doctorally trained nonphysician health care providers.
5. PAs will be better positioned to help alleviate physician shortages. Projections show a physician shortage of 200,000 in the United States by the year 2015.¹ Shortages are predicted in many specialty areas.
6. Doctoral degrees will enhance and elevate our profession as a whole.
7. Doctoral degrees would make PA training more proportional in length to physician training.
8. Graduates would enjoy a higher level of confidence from their employers and patients.
9. Doctorally trained PAs would enhance support for state and federal lobbying efforts to increase Medicare and Medicaid reimbursement for patients seen by PAs.

Cons

1. Patients might confuse doctorally trained PAs with physicians.
2. PAs and physicians may fear that their job security will be jeopardized by doctorally trained PAs.
3. Doctorally trained PAs might create their own rogue specialization.

4. The lack of a specific, clinical doctoral PA model to follow would make it difficult to craft a legitimate doctoral program.
5. Specialty-trained PAs may be limited in their job opportunities and restricted in their practice options. Unlike generalist PAs, specialized PAs may lose the freedom to move between practices in different specialty areas.

Let me address each of these objections in turn.

Patients might confuse doctorally trained PAs with physicians. This is a potential problem with all PAs but perhaps more so with doctorally trained PAs. It is important to avoid confusion for patients, but not difficult to accomplish. We must teach doctoral PAs not to introduce themselves as “doctor” and not to wear name tags that say, “Doctor Jones.” A more appropriate introduction would be, “Hello, Mrs. Brown, I’m Mr. Jones, one of the emergency department physician assistants.” An appropriate name tag for a doctorally trained emergency medicine PA would read, “Mr. Jones, DScEM PA-C.”

Physicians and other PAs may fear that their job security will be jeopardized by doctorally trained PAs. Let us consider what happened to emergency department (ED) physician staffing after the creation of the American College of Emergency Physicians and subsequent board certification in emergency medicine over 30 years ago. No one was pushed out of the market. In fact, the inclusion of residency-trained EM physicians was so gradual that there was plenty of time for non-residency-trained physicians to be gradually replaced as they retired. There are not now, nor will there likely ever be, sufficient residency-trained EM physicians to staff every ED in the United States. This logic can be reasonably applied to most specialty areas.

Doctorally trained PAs might create their own rogue specialization. We already have EM specialty-trained PAs, but we do not have, nor are we asking for, national PA certification in emergency medicine. A doctoral degree in EM or any other area does not constitute board certification by a national PA regulatory body.

The lack of a specific, clinical doctoral PA model to follow would make it difficult to craft a legitimate doctoral program. The U.S. Army Emergency Medicine PA Fellowship at Brooke Army Medical Center offers a demanding academic program. We have been steadily improving it in anticipation of stepping up to a doctoral program. Additionally, there are similar professions, like physical therapy, that could provide a guide in crafting a doctoral degree for PAs. In fact, the need to develop a curriculum from scratch could be a plus because

we can learn from the mistakes and shortcomings of similar programs.

Specialty-trained PAs may be limited in their job opportunities and restricted in their practice options. Unlike generalist PAs, specialized PAs may lose the freedom to move between practices in different specialty areas. There are several things to consider here. First, no PA has to specialize, just as no physician has to complete a residency in order to practice medicine. Second, any PA who does complete specialty training is not required to work in that field. A specialty-trained PA is free to work in his or her area of specialization, acquire another specialty, or revert to being a generalist PA. The fact that a PA completes specialty training in no way limits his or her job options. Third, PAs without specialty training are still able to work in specialty areas. For instance, an astute PA can still work in many EDs despite the lack of EM specialty training. True, in some instances they will be less competitive than someone who is specialty trained in that area, but they are certainly not prevented from applying for a job or from being hired for that job simply because specialty training exists in that area. If we look at the training of our physician colleagues in the ED, we can see that a wide variety of people regularly work in all manner of EDs throughout the country. Finally,

there will always be a subset of PAs who are interested in specialty training. These people know what they want and won't make the commitment to specialize unless they are very interested in that area. The small percentage of them that eventually find themselves unhappy with their work have several options, as outlined above.

I believe we are on the cusp of a period of great growth and development in our profession. We *must* grow and develop or we will wither on the tree of complacency. Let us not become mired in the past, but open our minds and embrace the possibilities that the future holds. Let us reach toward our destiny by endorsing the concept of clinical, professional doctoral degrees for specialty-trained physician assistants.

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References

1. Cooper, RA. Weighing the evidence for expanding physician supply. *Ann Intern Med.* 2004; 141(9): 705-14.