Episode 26 – PAs and their role in patient care

Intro music: 0:00

Podcast introduction: 0:09
If you have never come across a physician assistant in your journey through the health care system? Well, I'd be very surprised. This is Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board, and this is MedBoard Matters. Physician Assistants, or PAs as they're commonly known, are everywhere in health care, and their numbers are growing. For the last several years, the number of PAs licensed by the North Carolina Medical Board has risen by about 7% each year. That's much faster growth than we've seen among physicians whose total number in North Carolina has increased at a rate of about 2% per year. In large part, this is because physicians train for quite a bit longer than PAs before becoming licensed. What these trends mean is that while physicians are still by far the largest group of medical professionals regulated by the Board, PAs account for an increasing percentage of our total head count. Five years ago, in 2017 PAs represented 14% of the Board's licensee population. Today they account for 17%. So, if you haven't encountered a PA yet, it's probably just a matter of time.

Interview with Molly Calabria, PA-C (President) and Meg Beal, MMS, PA-C (President-Elect): 1:21
JFB: PA appreciation week is observed each year from October 6th through October 12th. In that spirit, we thought it appropriate to dedicate our October episode to learning more about the PA profession. I am delighted to welcome two PA leaders in North Carolina to discuss their dynamic and growing profession. Molly Calabria is a physician assistant who provides primary care to patients with a family medicine practice in Durham. She's the current president of the North Carolina Academy of Physician Assistants, the state's only membership association dedicated solely to PAs. Meg Beal is a PA in internal medicine at UNC Health Care. She is also a founding faculty member of the UNC Chapel Hill PA program, where she's worked since 2015, as well as the President Elect of NCAPA. Molly and Meg, thank you so much for joining me. I'm really excited to feature PAs on the podcast. I wanted to ask you both and we'll start with you, Molly, to just tell your story. And Molly, I'm cheating a little bit because I know you have a really interesting story coming from a family of physicians and actually even starting out in medical school and then somehow transitioning over to being a PA. And I wondered if you could talk about that and tell us just, you know, how did you come to the conclusion that you would really be better off as a PA?

MC: Sure, I'm happy to talk about that. So, I will start by saying that my story is not the typical path to becoming a PA. I think most people who become PAs have really thought about their choice in terms of what kind of health care provider they want to be and made a really sort of thoughtful decision about wanting to become a physician assistant. For me, I came to that decision much later than most. So, as you mentioned, I actually had started medical school before I sort of realized that that wasn't the right choice for me and figured out this PA thing was really a better fit for me. So, the backstory there is that I grew up in a family with several generations of physicians on both sides. My dad is an infectious diseases doctor. He did his training at UNC and his grandfather had been a physician. My mom's dad was an internist and his father was an ophthalmologist. And so, sort of in my family, you know, if you were going to go into health care, the sort of default setting was that you were going to become a physician. My mom was actually a nurse for a while, and she loved patient care. She in some ways was a sort of different inspirational story in that when I was in elementary school, she realized that that was not

actually what she wanted to do with her life, and she went back to school and decided to pursue a career as an English professor. She's sort of a great model in that she decided she wanted to do something different, and she pursued that. And I will say, by and large, my family was a lot of physicians. And so, you know, for me, I loved science. I knew I wanted to do health care. So, becoming a physician was sort of what I thought I would do. And I grew up in Iowa where there you know, I certainly occasionally would see a nurse practitioner, but I honestly just never saw PAs when I was young and I didn't really know what a PA was. So, when it came time to thinking about pursuing a career, I applied to med school and I actually started med school. And when I was in my second year of medical school at the University of Iowa, I was in some classes with PA students and Iowa has a great PR program, and it was in sort of starting to get to know some of those PA students that I realized in a lot of ways they were a little bit more like me. They had taken some time working in health care settings before going to grad school, which I had done. I had been an AmeriCorp member, doing some health education. I'd done clinical research in infectious diseases before applying to grad school, and I also had sort of started to realize that I had a lot of different interests in terms of providing health care and had a little bit of concern that, you know, let's say I picked oncology or I picked infectious diseases and got into that specialty and then I wasn't happy or I wanted to change specialties. As a physician, you've gone through all this specialty training and then you're kind of, you know, you're pigeonholed. And so, I realized as PA you're really flexible. So, you have this generalist education and training, and then you're out there and you're working and you get some sort of on the job training where you're working. And then let's say you're working on family medicine like I do now. I want to pursue a job in a specialty. I applied for that job, and I get some on the job training and I can change specialties. So, that was really appealing to me. And I think also as a woman who was a little bit older going to grad school, the idea of doing a shortened grad program without a residency, I knew I'd be out and seeing patients quicker and that to me was really appealing. And so, it didn't take long after sort of being in those classes and thinking about it that I thought, you know what, this is just a better fit for me. So, I sort of decided to up and quit med school and applied to PA programs. And here I am, eight, nine years after finishing PA school now and happily practicing family medicine.

JFB: Yea, Meg, I would love to hear how you got started.

MB: Sure. So, my story is a little less exciting, but I um...you know, I worked in the health care setting for a while till I figured out kind of what really fit me best. It was actually working here at UNC in the Internal Medicine Clinic before PA school where I was exposed to working with physicians, with residents, with nurse practitioners, with PAs, with clinical pharmacists, social work, you know, just such a broad and incredible team and could really watch all the pieces kind of come together and providing care for patients and looking around to kind of identify where do I see myself really fitting in on the team and just the dynamic role of the PA and doing so many different things. One of the PAs is kind of our anticoagulation expert, where all the physicians and residents would go to him and ask for his opinion on things. We had another PA who could do all the really challenging hypertensive management patient cases or diabetes management, and also see their own primary care patients and have these really unique and special relationships with the patients they were providing care for and just watching that and the level of trust that their patients had in them, but also that integral role of being embedded on a team really fit me. And I said, that is where I want to be because I love getting to be a part of a team, kind of contributing to the team effort, but then also being able to forge these relationships with

patients in different ways depending on whatever their needs were, and the need of the medical team was where I could kind of fit that role. That really ultimately spoke to me. I had a mentor who I had volunteered with in college at a free clinic in Charlotte, and I wasn't quite sure what she did. And then after getting to work in that setting, I realized she was a PA. She owned her own free clinic. I got to work with her and kind of, you know, keeping in touch with her and talking about all the opportunity, you know, is just so, so broad. So, I think there were a lot of different pieces that kind of fell into place for me to ultimately find that solution of where I fit in on the health care team. But I certainly never looked back and have really enjoyed getting to be a team player for our patients and our medical team.

JFB: Great. Well, thanks to you both. I think it always sets the scene nicely just to sort of hear people's stories and what drew you into the work that you're doing. From there, you both mentioned something that I wanted to touch on, which is that both of you had worked in health care roles before training. And I did not know until I learned from our former assistant medical director, who was a PA, that that's a requirement before you can apply to PA school. So what roles were each of you in? I think you mentioned Molly, AmeriCorp doing health education. I don't know if that counts as clinical hours, but.

MC: Yeah, so my so I did a year of AmeriCorp and it was a really great program that was co-sponsored by the Washington AIDS Partnership and the National AIDS Fund. So, I lived in D.C. and I had a clinical role where I was going to the Children's National Medical Center. So, I did some health education workshops working with adolescents, both males and females, doing a lot of reproductive health education. And I also did a good amount of HIV testing and counseling and then also like STI testing. So, there was some health education and then also working within the adolescent clinic there. So, I did that for a year and then I got a role as a clinical researcher at UNC doing some HIV prevention research that was really interesting, focused on young black men who have sex with men. There have been some really interesting research that have come out about the prevalence of HIV, specifically at historically black colleges and universities. And so, it was a really great transition from the work I've been doing.

JFB: And Meg, you mentioned working in the internal medicine clinic at UNC, but you didn't say what role you had.

MB: Sure. So, I did that for a couple of years. I was a care assistant, so I essentially worked with the various providers, primarily with patients who had diabetes, helping with managing their diabetes, patient education. And prior to that, I also, Molly, we may have been in DC at the same time, I was doing clinical research at the National Institutes of Health in pediatric obesity and got to work with young children then with some, it was an excellent experience kind of getting to watch the clinical research process and how all things worked and caring for patients then too. So, a couple of different type of roles. I will say, you know, a lot of people have the question of, well, how does PA school go so quickly? And you really have the ability to you know, take that information and integrate as a medical provider so soon. And I really think that drawing from context before PA school is really essential for all of us to be able to quickly integrate so much complex information and then be able to go out into practice. And so those years of experience and whatever capacity they are, are really valuable. And our training model.

JFB: Yeah, I suppose that's why it is a requirement before entry to PA school. And how many hours is it that you have to have?

MB: It varies for each program, actually very interestingly. For UNC for example, it's 1,000 hours minimum, but all programs have a little bit of a variation of their requirement.

MC: So, I was going to just mention that, you know, the clinical experience I think varies greatly. And, you know, Meg is at an academic institution, she probably has a lot more recent knowledge of what people are doing. I'll just tell you from my PA school experience, it was really helpful, just drawing from different people's experience. So, for example, you know, I told you I did some clinical research health, education. So, when we would be studying for exams, for example, people would come to me and if they had questions while, we did our infectious diseases unit or I then later did a little bit of oncology research and but then in my class we had two former Special Forces vets who were so helpful. We were doing like procedures. We had some former EMTs, some people who had been athletic trainers who were super helpful during Ortho. And so, it was this really nice sort of community where we were able to draw on our backgrounds and really help each other because we all had such different backgrounds. And that's what felt so different too is we really kind of came together and…and the different backgrounds and the different previous experiences really kind of helped push us along and also pull us through, if that makes sense.

JFB: Or I can see how that would happen. I think we should probably get down to brass tacks and talk about what is a PA and what can a PA do. And then maybe we can talk a little bit about your education in more detail.

MB: Yeah. So, a PA or physician assistant is an advanced practice provider, so we go through training as a kind of a medical model of training. So, diagnosis, treatment, therapeutics, kind of pathophysiology of disease and our role in medicine really is so variable depending on the setting in which we work. The PA profession was built to improve and expand access to care. That was the foundational principle of the genesis of the PA profession. And what's really neat is to this day that's still our role, is to continue to improve and expand access to care. So, you'll find PAs as medical providers in all different settings, working in collaboration with the physician. So, we are inherently always part of a care team and really filling the need that exists. So, I have colleagues in the cardiothoracic ICU. I have colleagues in transplant surgery and rural primary care medicine. You know, really, it's just such a vast array of settings in which we provide care because the PA profession is really built on a generalist training model and PAs graduate with a foundational knowledge to be able to then enter into any space and provide care. There is some inherent on the job training in some instances, depending on the level of specialty that a PA works within. But we all come with this kind of foundational knowledge base that allows us to integrate into a team and help fill the needs that exist. And so, PAs can diagnose conditions, PAs can treat conditions, we can prescribe medications. It's really state dependent kind of the extent of prescriptive authority. North Carolina is a very PA forward state, PA friendly state. We're able to provide prescriptions for controlled substances when appropriate. We can also first assist in surgeries, provide post-operative care as well. And in women's health PAs, have a great role to. So, across the board, from pediatrics to geriatrics to surgical settings, really anything in between, we can provide kind of the full spectrum of care, knowing that throughout that we are on a team with a physician as well providing care.

JFB: Yea, Molly, did you have anything to add?

MC: I think Meg explanation covered all the bases.

JFB: Okay.

MC: The bottom line is that I would say PAs are medical providers who are able to practice in all areas of medicine, all specialties of medicine. They're highly trained, highly educated medical professionals who provide really good patient care and expand access to care. So, I think that that's really sort of where the rubber hits the road and why we hopefully can really help sort of expand that access.

JFB: And I feel like I would be remiss if I didn't mention that North Carolina is the birthplace of the PA profession. We don't need to spend a lot of time on that. But there was, of course, a Duke physician, Dr. Eugene Stead, who, as I understand it, the original PA program was sort of inspired by the training that field medics in the military receive. Do you want to fill in the blanks for our listeners? I'm sure you're probably more knowledgeable.

MC: I would just say part of the reason that the clinical experience is required before PA school is coming from that model. So, the first class of PA students graduated from Duke in 1967 and they were Navy corpsman and so the idea being these people were coming back from war with all this practical experience and it didn't make sense to make them sit through four years of medical school and then, you know, a minimum of three years of residency before they could go out and put all that knowledge to use. So, that has evolved to where now people applying to PA schools need to have some clinical experience before they can apply, and that is able to kind of make it this continued rigorous sort of training and education. Now, some programs do still have an emphasis on veterans, and Meg can speak a little bit more to that. So, I'll let you take over, Meg.

MB: Yeah, absolutely, Molly. So, UNC is one of those programs or several in the state and then, you know, nationally, but really recognizing the value of this highly, highly trained medical provider in the military and various kind of medic roles that will then return and once separating from the military and entering the civilian sector, their skills don't directly translate into any kind of profession, and we have immediate access to. So as Molly alluded to, having them go through the PA training model makes a lot more sense for them to then be able to quickly translate that skill set, build upon it and then enter into the workforce on the civilian side. So, UNC's PA program was really built kind of going back to the genesis of the profession, talking to the military in North Carolina, saying, hey, we really have this need. We have a lot of people who are leaving the military with these amazing skills and…and how can we really help support them to ensure that they can build upon those skills and continue to work? And so that was kind of the…the genesis for this program. And one of our missions is to ensure that we provide training for these highly skilled veterans.

JFB: Great.

MB: I will say, too, so Dr. Stead is the founding father of our profession who helps build the first PA program at Duke. And PA Day is actually October 6th, which is the date that the first PA graduates graduated. And it's also Dr. Stead's birthday. So just a fun fact.

JFB: All right. Well, I will tell you, that is the inspiration for us choosing this topic for our October podcast is that we celebrate every year PA Appreciation Week. But I did not realize that October 6th was such a

momentous date, but that's great. Meg, you had touched on this earlier that PAs are everywhere across the state. One thing I've been with the medical board going on 15 years now, and since I came to the board, one of my roles has been to pull together data for our annual report and part of that is looking at the demographics in the state. And pretty early on, I spotted just really strong and steady growth in the PA population. And, you know, I can't tell you when I started to annually track it and notice, but I can tell you that at least for the last seven, eight years, the annual growth rate in the PA population here in North Carolina has been steady at about 7% a year, which has always astonished me. And we are in fact very close to reaching 10,000 licensed PAs in the state of North Carolina, which is amazing. I just wanted to ask both of you is like, how is this happening in the state of North Carolina? I mean, where…how is the PA profession attracting these folks into PA programs? How are we producing so many graduates? And how are we being so successful at keeping them here to practice in the state?

MC: Well, I think one thing is we've had a growth in the number of PA programs, even since I think Meg and I graduated from PA school, both of us graduated from PA schools in North Carolina. And then I think it says a lot about the state of the PA profession in North Carolina that so many PA students end up staying to be professional PAs in the state of North Carolina. I think for a long time, North Carolina has been seen as one of the best, if not the best place to practice as a PA. And I will say, it certainly has been my mission as president of NCAPA and for a long time as a volunteer at NCAPA to ensure that North Carolina stays a great place to practice as a PA. I think, you know, of course, there's all those other things that people care about in terms of where they want to live and where they want to work. And that's quality of life. You know, I live in the Triangle, and we've got great outdoors spaces. We've got great education for our kids. It's all those other things, too. And I think in general, North Carolina is a place with a population that's increasing. But certainly, I think we train PA students well. We have a lot of really great PA students, a lot of great PA programs. Meg is certainly helping with that for sure. So, thank you, Meg. And then I think it's a matter of making sure that we remain an attractive place that PAs want to actually practice. And that's really important and something that we have to, you know, stay on our toes for.

MB: Absolutely. I do want to echo just the importance of having a state kind of representing academy to really help kind of behind the scenes continue to amplify the voice of the profession. And I think a lot of people, as Molly mentioned, North Carolina is a very PA friendly state. We are able to practice without so many barriers or limitations. And that's in large part because we do have such great advocates for the profession in the state who make sure that that that's the case and to kind of get the message out to stakeholders of what our profession's about, what PAs do. And then the more and more we can interact and interface with patients and help one patient at a time. For those who may have not gotten to see a PA yet, help them understand, you know, who their PA is and what their role is on their care team. I think that just helps to kind of grow the understanding and the warm environment for our profession to continue to grow.

JFB: That leads right into a question that I had wanted to ask each of you, which is what do you want patients to understand about what they're going to get when they go into a patient visit with a PA? Because while PAs are very visible in our health care system, certainly here in North Carolina and I imagine everywhere, you do still occasionally get some pushback from patients.

MC: So, I think the best thing to do is, you know, assuming that they've gotten in the door and they're seeing me for an appointment is just to give me a chance. There are patients who are going to be open minded and give us a chance. And I would say the vast majority of the time they're going to come back and see me again. There are patients who are going to have their mind made up that they only want to see a physician. And that's fine. You know, they can see a physician. But I think that a lot of times if a patient they've just not had the experience of seeing a PA, they go through that encounter, and I listen to them and I am able to hear their needs. I think they're going to come out satisfied. And I think that's the biggest thing, is just to try to have an open mind, be willing to see me for an appointment. You know, I think they're going to be happy in the end because I do think that PAs provide really excellent health care. And so, I think that's the biggest thing is to try to be open minded, give us a chance. If you're not happy, you're always going to have other options. But…but give us a chance.

JFB: Meg?

MB: And also, just to remind them that we are embedded within their care team. We work closely with all the members of the patient's care team. We're a highly trained medical providers and are really looking out for our patients' best interests. And yes, give us a chance so we can show you that. And nothing is more satisfying than starting a visit with having that conversation, giving a patient the opportunity to ask questions, to better understand my role and to have them leave satisfied and wanting to see us again. You know, I think that's always a win, a victory. And it helps the patients gradually understand that, yes, we are trusted care providers who are here for you and…and ready to see you and looking forward to these visits and to helping you understand more about our profession. It's not something you're as familiar or comfortable with.

JFB: Well, thank you for that. I think certainly that's part of our goal here, to educate people about, you know, all of the things that PAs do. One thing I wanted to ask, we've talked about how PA education really provides that foundation for primary care, but I do know that there has been just tremendous growth in the opportunities for PAs who wish to specialize. And Meg you might be best positioned to address this because of your role in academia. But can you talk about the growth in opportunities for PAs who do want to specialize?

MB: Absolutely. So, there's been kind of a genesis of more post-graduate training for PAs. And so, while PAs can still absolutely graduate from a PA program and then enter into a subspecialty, a surgical sort of specialty and begin working right away, there's also the opportunity to further more organized training for PAs. So, if a PA chooses to enroll in a postgraduate PA residency, or fellowship, then they can have additional on the job training essentially, but in a very organized fashion through various post-grad programs where they can have more directed, specialized, focused training in that particular area to help them have the competence and that kind of more specific skill set as they go into practice from there. So, it's great because we have these opportunities in so many different settings. They're primary care, postgraduate fellowships, there are surgical subspecialty, post-graduate fellowships and so many different and critical care, so many different areas of medicine to provide just additional training for a graduate who feels that that would be best for them or to kind of help position them well for their next chapter. There are also postgraduate training opportunities in education for PAs. So as far as getting kind of a doctorate in different areas of medical practice, so really there's been a lot of growth in terms

of what you choose to do with your PA career and kind of the level of training or additional training that a graduate would like to pursue. So, lots of exciting kind of possibilities for PAs.

JFB: One thing that we haven't really talked about explicitly yet is supervision. I think we've mentioned, you know, the team-based practice, collaborating with physicians, but certainly in North Carolina and still in many other states, by law, PAs are required to have a supervising physician in order to practice lawfully. Can you talk a little bit about what that looks like? Because, again, in the lay world, non-medical world, when you say supervision, that implies like you're training somebody to do something. That they're not a fully qualified professional. That's not the case in your profession. I would love to get your insights into how supervision actually works on the ground in a clinical practice.

MC: So, I can tell you in the practice where I work, I'm in a primary care practice with two physicians and five PAs. So I have a supervising physician agreement filed with the medical board, and that is someone who I meet with every six months for a supervising physician quality meeting where we talk about different things that maybe I need to work on, or I might go over some charts that I'd like to review with him, but that sort of the formal aspect of it, in reality, this is someone who, depending on the day or the week, I might talk to him ten times a day about patients, or I might talk to him once in the week. It just kind of depends on how complicated patients are and what's going on. What I will say is that part of the reason that I joined the practice where I am is that I wanted to be at a practice where I felt very comfortable that I would be able to talk to my supervising physician, ask questions, not feel like a burden, and that that is something that to me, especially as someone who, when I was first hired here, hadn't been practicing a really long time, that was really vital to me, especially in family medicine, where I feel like I'm always learning. You know, to me, I want to have that level of comfort. But I will say to, you know, I work with a lot of really qualified providers, so I have four other PA colleagues who have also been practicing a long time. So, the PA that was my preceptor and my family medicine rotation is actually one of my colleagues now, which is great and she is just a phenomenal PA. She has won teaching awards. She's just the best. And I trust all of my colleagues. So, on paper, I have one supervising physician, but in reality, I go as much to my PA colleagues as I do to one of the two physicians at the practice. I think that, you know, I'm in a family medicine clinic. We're all seeing patients all day, every day. That's a very different clinical situation than, for example, a PA who's doing who's a first assist in surgery. So, every clinical situation is different and what it looks like on the ground is different for every PA in every different work setting. For example, a PA who works in an emergency medicine practice where they're on, you know, they're with a different physician, different set of providers, every shift that they work. For me, I'm working with the same other six providers on a really regular basis. And we're all seeing, you know, our own patients most of the time, occasionally seeing each other's patients.

JFB: I think that's a great point that it's going to vary based on specialty, practice setting, all those different factors that affect it. Meg, did you have anything to add?

MB: I think Molly did a good job of distinguishing between kind of the formality and certainly the important kind of medical/legal aspects. And I think a lot of people have this vision of the physician kind of looking over the PA's shoulder maybe, or which is not at all the case. I think there is certainly an element of trust that's established as a PA is trained and on the job in providing care. And I do think there's really more of a collaborative and supportive relationship or just as Molly alluded to, for more

complex cases or things, you're able to reach out to your supervising physician. They don't have to be on site necessarily for that to happen. But you have that open line of communication should more complex cases be before you. But really, there's a lot of ability for PAs to practice without necessarily needing to reach out for help, but always being able to do so when needed and having that kind of supportive relationship is really instrumental to the care we're able to provide.

JFB: You know, I wondered if each of you could offer some advice. You know, we have a lot of the PA programs are getting ready to graduate classes. They're going to be part of the wave of PAs that takes us over the top of that 10,000 mark that I was talking about. I think this is such an important choice for a PA is who they choose as their first employer, their first supervising physician. And I wondered what advice you would have for those new grads that are going out there and trying to get started about how to make sure that you land in a practice environment that's going to really be supportive and is going to help you get started in the best possible way?

MB: That's a great question. I would definitely encourage new graduates and those who are training new graduates to really encourage them to ask what does onboarding, what does kind of orientation, what does the initiation of a new graduate into your practice look like? What do you envision day to day being my role, how do you envision integrating me into the practice? Kind of what level of support is typically provided for new employees and really asking those questions and being very honest with what they feel that they need upfront. I do know just anecdotally, a lot of new graduate PAs who change jobs early on, it's because that relationship may not exactly be what they envisioned. And so not being afraid to ask those questions in advance because for their supervising physician, it's also, I can imagine, very helpful to know kind of what they can do to support that new graduate. So not being afraid to have those conversations and to kind of flesh out what does that onboarding, and kind of initial support look like.

MC: If there's an opportunity to do like a half a day of shadowing of another PA in the clinic, that's something that can kind of give someone a really good chance to see what a relationship between providers in the clinic is like. Now, like I said, I was really lucky. I did my family medicine rotation at the practice where I work now, so I really had some good insight into how people here interact with each other, the level of comfort they have with one another and…and that was really reassuring to me when I decided to take the job that I have now.

JFB: That's great. You know, it's interesting, over the last several months, I've had the opportunity to give a short presentation to graduating PA students' kind of on the medical board licensure process and things like that. And one of the pieces of advice that I give is just to be careful when they're selecting their supervising physician and their…their first job. And one of the things I say is, don't forget you're interviewing them just as much as they're interviewing you. So, I'm glad that that lives up with your advice. I feel more confident now going to speak to those students because you know, they work so hard, as, you know, for their degree. And I know I've been so impressed by the quality of the students that I've been able to encounter at the North Carolina PA programs. And, you know, it's hard not to root for them and want them to get out and be successful. So, I will continue to give that advice. That is that all the prepared questions I had for you. But I will offer each of you the opportunity just to give any parting thoughts that you have that you'd like to leave our listeners with.

MC: I would just say that if they are PAs listening, a couple of things. One, please stay in North Carolina. We love having this as a PA friendly state. We love being able to tout the number of PAs, the quality of PAs and how much patients love seeing their PAs. We hear it all the time. Oh, I love my PA. Whenever I introduce myself as a PA. The other thing is, I'm president of the NCAPA and we are the only organization that represents PAs in the state of North Carolina. And we work really hard to advocate for all PAs, but it's so helpful when we have more PA members because then we are able to amplify that voice. So, if you're not a member, this is a shameless plug. I would absolutely encourage you to consider membership because it really does help advocate for you to be able to practice to the full extent of your training. And that really is just so important so that the state is a great place for us to be able to practice as PAs.

JFB: Meg, I want you to have your opportunity to give us some final words, but I will just say as evidence of that, I believe NCAPA was one of the driving forces behind how the North Carolina Medical Board got a dedicated seat for a PA member. So now the Medical Board has 13 members, one seat is reserved for a PA member, so.

MC: That is correct.

MB: I just wanted to thank you so much for having Molly and myself join you today and to kind of share our passion for the PA profession and it's just it's really a privilege to get to work as a PA and especially as a PA in North Carolina. I need to join Molly in a shameless plug. Just encouraging kind of PAs, future PAs, perspective PAs, soon to be PA graduates to join kind of a community of PAs and have that collective voice. That's what the North Carolina Academy of PAs really does. Just as you mentioned, Jean, in terms of having a seat at the table at the medical board and helping us to really make sure that we're a part of helping the patients in the state of North Carolina, the people here, and do all we can to expand access to care and improve patient care. And so, thank you for allowing us to kind of share our perspective. And we hope that more patients will learn about us and get to and get to have the privilege of providing care for…for more and more in our state.

JFB: Well thanks to you both. This has been a delight and it is an honor to celebrate PA Appreciation Week with you. Thank you.

MC & MB: Thank you so much for having us, Jean. We really appreciate the opportunity.

Episode closing: 36:30

Well, that brings us to the end of this episode of MedBoard Matters. I hope you have a much better understanding of PAs and their role in the health care delivery system. I know I learned a lot from our guests. If you would like to learn more about PAs, what they can do clinically and their history in North Carolina, check out our show page at www.ncmedboard.org/podcast. If you are a PA, we have also linked to some key resources for you on the page, so you may also want to take a look. As always, we welcome your comments, suggestions, and constructive criticisms at podcast@ncmedboard.org. If you found this episode helpful, tell a friend, give us a share on social media. You know the drill and thank you for listening. I hope you will join me again.