March 24, 2026

RE: Summary of Testimony on S163

From: Matthew Greenberg, MD, FACEP

Chair, Vermont Board of Medical Practice

Madam Chair, committee members, thank you for allowing me to speak today. My name is Matt Greenberg I am here on behalf of the Vermont Board of Medicine that I currently Chair. I am an Emergency Physician with 25 years of experience, the last 15 years here in central Vermont. I was asked to speak on the Boards position on adding Physician Assistants (PAs) to the language of S163 hence enabling PAs to also be "attending of record" for admitted hospital patients. Unfortunately, as this modification came up only recently the Board has not met nor had a chance to discuss and render a unified opinion. What I can discuss is the Board's role in regulating and monitoring those that carry Physician Assistant Licenses here in the state of Vermont. What may also be helpful is for me to explain a bit about what makes a PA qualified to do what they currently do in medical practice, what their baseline training is like, and why that may make them candidates to take on this role.

I should first disclose that over my career I have worked with many PAs and APRNs. These interactions have almost always been positive. I have also provided clinical education to many: this includes being primary preceptor to trainees from the University of North Dakota Physician Assistant Program and The Rocky Mountain University APRN program.

The board is charged with licensing and monitoring PA licenses to ensure that they are appropriately trained and carry the expected credentials to practice medicine. Additionally, under Vermont statutes a PA must have a collaborating physician that is available to consult and who will perform periodic assessment to ensure the highest levels of practice. The collaborating physician must be of a similar specialty. The collaborating physician does not need to see the patients who the PA is seeing nor do they need to be physically present. They simply need to be available for consults if necessary. This is perhaps one of the most noticeable differences in the licensing and State sponsored oversight of PAs vs APRNs. Hospitals, however, may make more stringent rules regarding both PA and APRN practice oversight.

Ultimately what a practitioner is appropriate to manage has most to do with training and experience. PA and APRN training are similar, but not the same. I have included the table

below that I created with averages as reported by the AMA, Open Evidence, and the AAPA. It is for relative comparison and represents only generalizations.

Similarities in training generally include a basic understanding of anatomy, pathophysiology, pharmacology, psychology etc. The differences have more to do with approach to learning and the background that applicants come from prior to training. For example, PA programs are postgraduate training programs that generally require medical experience for entry (often hospital techs, EMTS, scribes etc). The structure of most PA programs more closely resembles that of medical school with generally continuous full time parallel didactics followed by full time clinicals with most programs lasting about 2 yrs. Many APRNS are nurses in full practice already and hence more of their programs are sporadic or serial in nature over a longer period so that trainees can continue to practice their profession.

My impression and experience is that PA training programs are more similar in structure and content than APRN programs which offer more variability in process, structure, and content. This probably has more to do with the fact that there have been more PA programs around for a longer time and the fact that they have a single major accrediting organization. They also have a single licensing exam. Upon graduation, PA students are awarded a masters level degree. Licensure to practice as a PA requires subsequently passing the national licensing exam. APRN graduates can be either Masters level or Doctorate degrees. APRNS also have to pass one of 2 licensing exams.

As PA training is more typically hospital based one could argue that they are well positioned to take on the responsibility of "attending of record" if this role were to be expanded beyond the traditional role of a physician.

Beyond initial education are the additional processes that hospitals and health care organizations use to ensure that their providers are appropriately trained and continue to maintain high levels of care. The credentialing and privileging processes ensure that individuals have the appropriate training and competency necessary for the position that they hold. These processes can be reactionary (ie changed as necessary by outside pressures such as finances, workforce demands, legal concerns etc) and do require appropriate incentives but, provide a back stop for initial and then continuous appraisal of medical skills and knowledge. The specifics of credentialling are further regulated by CMS and their monitoring organizations such as the Joint Commission.

As with most things, experience often counts for more than a specific title or degree. Allowing hospitals to consider more finessed details in their credentialing and privledging

processes may offer additional oversight to the "attending of record" status. This could provide an a further layer of protection and quality assurance to the citizens of Vermont.

In my opinion the larger decision is whether or not to move away from the traditional role of the physician as the "attending of record". This would be a large departure from our current standing. There are significant arguments to both sides of that decision that include finances and quality concerns. If that decision is made however, I believe it is only logical to offer that status to both Physician Assistants and APRNS.

The full Vermont Board of Medical Practice will discuss this topic at our next meeting on April 1st. I will be happy to provide a summary of that discussion and any consensus made after that meeting.

I am happy to answer any questions you may have.

Respectfully,

Matthew Greenberg MD, FACEP

	MD/DO	Physician Assistant	Advanced Practice Nurse
Level of Degree/yrs	Doctorate / 4 yrs	Masters / 2 yrs	Masters or Doctorate / 2-4
Residency/yrs	Expected / 3-7	optional	optional
Hours of training	15,000	2,000	1,500
# of patients seen in training	1400 – 3000+ Proceduralists, are often required to do about 1000 procedures	1000-2000	500-750
Educational Accrediting agency	LCME/COCA	ARC-PA	CCNE or ACEN
Licensing exam	USMLE steps 1, 2, 3	PANCE	AANCPB or ANCC
Training setting	Hospital based	Hospital based	Both with more out patient clinic based

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