March 16, 2015

House Committee on Health:

My name is Julie McNamara and I am a radiologist assistant (RA), which is also known as a radiology practitioner assistant (RPA). I am writing in response to the statements that the PA-C's Gregg Kosloff and Judah Gold-Markel have submitted on HB2880. I am also writing in response to a letter sent on behalf of Legacy health. This letter is only one point of view. Legacy radiologists are upset and would like to discuss the statements made, with Legacy, since they were not informed. They feel it is one sided and biased. I also ask for your understanding, in advance, on why this letter is 2 pages to discuss the statements.

I have had extensive training and education in radiation to first become a certified x-ray technologist (4 years). Then worked in many modalities in radiology for 15 years before going back to school for advanced training in radiology. This involved another 2 years to become a certified RPA/RA .This advanced training was an additional 2200 hours of highly supervised training with a radiologist to perform procedures (such as the PA-C's have mentioned), radiation safety adherence, and then show competency to a radiologist after many required patient repetitions. I have had 22 years in the imaging field and respectfully disagree with the statements the PA's above made.

The American College of Radiology (ACR) is a governing body and the primary body for which all imaging, dictation, and procedures are monitored for radiologists. The ACR disagreed with the American Society of Radiology Technologists (ASRT) recommendation to the PA society of the 80 hours clinical and didactic pathway. The ASRT is NOT a governing body for the imaging field. They provide continuing education for our field. The ACR recommended 40 clinical hours to be with a radiologist and show competency with a radiologist. This topic was brought up at one of the OBMI workgroup sessions (of which there were only two, not multiple) and the PA's listed above had major objections. The Oregon Board of Medical Imaging (OBMI) has no jurisdiction over PA's and therefore, has no control over allowing the request to move to legislature. A request was made at the first workgroup to include the Oregon Medical Board's opinion from radiologists. I can tell you there are about 25 radiologists I know of who said they never received any notice of this PA request and they do not approve. The PA's and the representative from the medical board only had a small sampling of physicians they polled. It was selected and biased.

The statement that PA's will "thrive in the fields that utilize this technology" has so far proven to not be a real need. There are plenty of radiologists who are specifically and highly trained to do these procedures. They (PA's) are essentially stating they can do them with limited training. Radiologists have 4-5 years specific training in radiology procedures (on top of medical school for a total of at least 12-13 years), and the PA's want to do it in a 40 hour online course in what they described in their letter as a "robust educational component". The statement "This will improve the timeliness of care to all of our patients, while preserving patient safety" by PA Gregg Kosloff, is only their opinion. There is no delay in care. There are plenty of radiologists to do these procedures and plenty of technologists who can step on a fluoroscopy pedal for the PA. If the PA's believe they will provide patient safety than why are there

documented cases of non-radiology physicians still giving radiation burns to patients? In a time where radiation dose is of high concern and the effects of radiation overexposure does not show up for weeks, months, or years later, I urge you to consider the safety of patients and staff. The PA's state they have extensive medical didactic framework in disease and metabolic effects. They might touch on the topic, but are not specialized in it. In my years, I have seen non-radiology residents keep their foot on the fluoroscopy pedal too long. A PA does not even have the same schooling as a resident and residents are already overexposing! They have overexposed the patient many times, let alone the exposure to the staff in the room, which is accumulative much faster, since they work in it daily. I have also seen these same people ask for the wrong contrast where a technologist had to stop them and question them. They always state along the lines of they don't know and will do what the technologist suggests for the department protocol. Many contrasts have contraindications and some of instant death.

These non-radiology workers do not have the extensive safety training to recognize this. Leave the fluoroscopy to the technologists who are already in the room to assist. There is no true need for the PA's to receive this pathway. We need to take a more in depth look in a non-biased statistical poll of all of the medical board to include a large population of radiologists. I urge you to reconsider and take time to look at this more closely. I also urge you, if you are considering this without further review, to require the 40 hours supervision by a radiologist. Oregon has traditionally been a state of strict laws. This would fall in line with making sure the PA's are providing the best patient safety and training by a radiologist, not the non-radiology physicians they currently work under. I respect PA-C's and the work they do, but they are not qualified to work in the most ionizing radiation field without sufficient education and training. Consider the years of training a RA/RPA has or even respect for the years of training our radiologists have to do these "simple" and "complex" procedures.

We have not all agreed on this bill. It has been biased. I also ask for your consideration in the 32 states mentioned there are not even regulations in some of those states. I also urge you to consider the approach the PA's have taken where they are bypassing the state medical boards and going to the radiation boards, knowing they have no jurisdiction over the PA's. The other states have approved the license because very few knew about it. This is exactly what we are finding out about in Oregon and in the exact same way. This needs to be addressed and reviewed further before decisions are made. The few interventional radiologists who have supported these specific PA's also have financial gain as they will be able to bill for them in the departments. I am concerned their decision is financial and not patient safety. For these reasons, I ask your committee to look into this further from a patient safety aspect as well as a better sampling of ALL of the Oregon Medical Board.

Lastly, the PA's stated during our two workgroups they were only interested in this license for line placement checks. It has been stated clearly, by Gregg Kosloff, their intentions are to do other procedures in radiology, putting more patients and staff at risk when there is no need and plenty of qualified staff to assist the PA's.

Thank you for your consideration,

Julie McNamara ARRT(R)(M)(CT), (RPA/RA)