



PA Scope of Practice

PAs are proven and integral members of the U.S. healthcare team. But what exactly do PAs do? And who decides? The boundaries of each PA's scope of practice are essentially determined by four parameters: education and experience, state law, policies of employers and facilities, and the needs of the patients at the practice.

EDUCATION AND EXPERIENCE

A broad, generalist medical education prepares PAs to take medical histories, perform physical examinations, order and interpret laboratory tests, diagnose illness, develop and manage treatment plans for their patients, prescribe medications and assist in surgery.

The intensive PA program curriculum is modeled on the medical school curriculum. The typical PA program extends over 27 continuous months and begins with classroom instruction in basic medical sciences. This is followed by rotations in medical and surgical disciplines including family medicine, internal medicine, general surgery, pediatrics, obstetrics and gynecology, emergency medicine and psychiatry.¹ PA students complete at least 2,000 hours of supervised clinical practice in various settings and locations by graduation.² Almost all PA programs now award master's degrees, and by 2020 all programs must do so.³

In order to practice, PAs must graduate from an accredited PA program, pass the Physician Assistant National Certifying Examination developed by the National Commission on Certification of Physician Assistants and be licensed by a state. To maintain their national certification, PAs must complete 100 hours of continuing medical education (CME) every two years and take a recertification exam every 10 years.

Like other health professionals, after graduation PAs continue learning in the clinical work environment and through CME. PA scope of practice grows and shifts over time with advanced or specialized knowledge, with changes or advances in the medical profession overall or with changes in the PA's practice setting or specialty.

STATE LAW

Although there is still some variation in state law, the majority of states have abandoned the concept that a medical board or other regulatory agency should make decisions about scope of practice details for individual PAs. Most states now allow the details of each PA's scope of practice to be decided at the practice level.

Many of the first state laws for PAs, passed in the 1970s, were simple amendments to the medical practice act that allowed a physician to delegate to a PA patient care tasks that were within the physician's scope of practice. These were followed by more stringent regulatory lists of tasks in some states, but these detailed methods of regulation proved impractical and unnecessary.

For example, in early 1996, the North Dakota Board of Medical Examiners changed the rules governing PAs to eliminate a procedure checklist and adopt a less restrictive scope of practice. Writing in the board's newsletter, Executive Director Rolf Sletten stated:

Historically, a PA's scope of practice has been defined by a checklist which ostensibly itemizes every procedure the PA is permitted to perform. The benefit of the checklist is that it is very specific and so, in theory, everyone (i.e., the PA, the supervising physician and the Board) knows the precise boundaries of the PA's scope of practice. In actual practice, it is simply not so. PAs function in a great variety of practice situations, in a wide range of specialties.⁴

FACILITY POLICY

Licensed healthcare facilities (hospitals, nursing homes, surgical centers and others) have a role in determining the scope of practice for PAs in their institutions. In order to provide patient care services within an institution, PAs request clinical privileges, which must be approved by the medical staff, and ultimately, the institution's governing body. This process defines a scope of practice that each individual is qualified to provide within that organization.

Institutions assess PA requests for privileges just as they do for physicians, including verification of professional credentials (graduation, licensure and certification) and documentation of additional relevant training, previous privileges and/or procedure logs, CME, or skills assessment under direct observation.

NEEDS OF THE PRACTICE

To a large extent, PA scope of practice is determined by physicians and PAs at the practice level. This allows for flexible and customized team function. As teams decide on clinical roles in a practice, the needs of patients and the education, experience and preferences of the team members shape these roles. Within each type of medical setting, from family practice to surgical facilities, the practice is able to plan for PA use in a manner that is consistent with the PA's abilities, the team's practice style and the patients' needs. Over the years, studies have repeatedly shown that it is appropriate for scope of practice to be determined at the practice level as the care PAs provide is of high quality.^{5,6,7}

CONCLUSION

As team practice evolves and research repeatedly shows the quality and safety of PA-provided care, states that once closely managed each PA's scope of practice are deciding that individual scope of practice can safely be determined at the practice level. As states recognize the dramatic potential of PAs to ease workforce burdens, they are broadening laws and regulations, enabling PAs to diagnose, treat, prescribe and manage a wide range of medical conditions without having to submit detailed practice descriptions to regulators. This model allows PA-physician teams to rapidly and efficiently adapt to changes in workforce needs, medical knowledge, technological advances, payment systems and standards of care.⁸

ABOUT AAPA

AAPA is the national organization that advocates for all PAs and provides tools to improve PA practice and patient care. Founded in 1968, AAPA represents a profession of more than 115,500 certified PAs across all medical and surgical specialties in all 50 states, the District of Columbia, the U.S. territories and the uniformed services. Visit AAPA.org to learn more.

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Last updated: January 2017