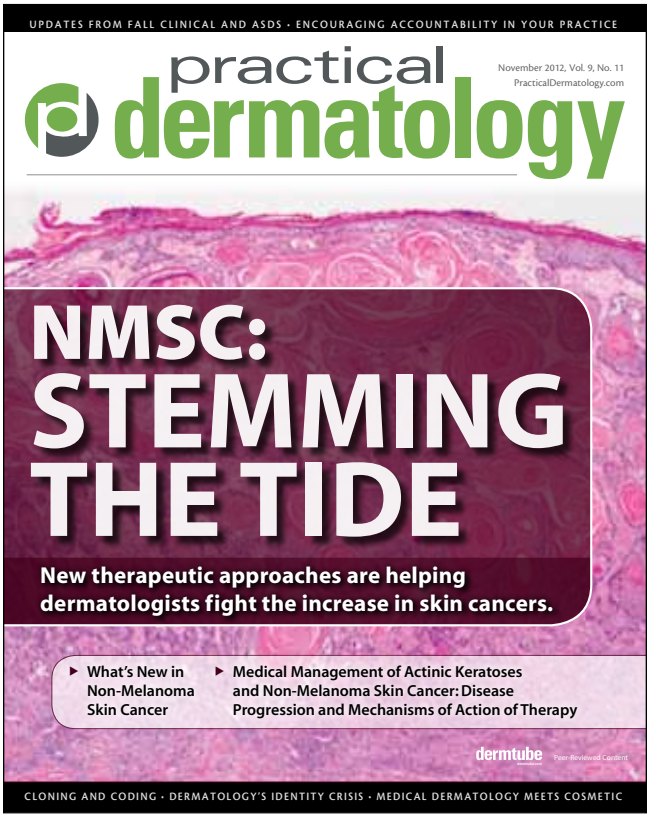
Clarifications for "We have an identity crisis": PAs' Training and Roles in Practice

The November, 2012 issue of *Practical Dermatology* contained an important article on the need for clarification and standardization of terms and titles for non-physician medical providers—physician assistants (PAs) and nurse practitioners (NPs). While the authors provided a crucial starting point for this conversation, there are several items within the article that require correction or clarification in order to avoid additional confusion.

I wholeheartedly agree with the authors that the abilities and limitations of both NPs and PAs are often poorly understood by physicians, patients, and each other, despite the fact that both vocations have existed for more than 40 years. This confusion continues to limit the proper utilization of both, potentially restricting adequate access to healthcare, particularly in rural areas. I present these brief corrections in the same spirit as the original article subscribed: to alleviate confusion surrounding the roles and training of mid-level practitioners as a component of improving patient care.

The authors assert that in dermatology, "Physician assistant workforce expansion occurs faster than the NP workforce as a result of shorter credentialing requirements and the fact that PAs are used to working in specialty areas." In reality, PAs share the same training model as physicians do and so experience a broad base of rotations in a wide variety of specialties during their clinical phase; resulting in a broadly trained practitioner with varied experiences. However, PAs don't actually specialize until they enter the workforce. This broad experience base does not come from a shorter educational experience. In fact, the table from which the authors indicate their own table was adapted[1] lists the following above boxed information regarding the amount of training for both.



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However, I must caution that the referenced table is a webpage from a physician assistant student, has not been published, nor is it peer reviewed, and its accuracy must be viewed skeptically. Regardless, the authors may be basing this "shorter credentialing" argument on their own table, which indicates that only a high school diploma is required

TABLE 1.		
	NPs	PAs
Time in Classroom	500 hours	1000 hours
Time in Clinic	500-700 hours	2000 hours

to enter PA school. In fact, 95 percent of all current PA programs that are fully accredited and in good standing with the physician assistant accrediting body (ARC-PA) offer a Masters in Physician Assistant Studies[2] as their terminal degree. Only one program currently allows PAs to enter directly from high school. It also is important to note that the Accreditation Standards for Physician Assistant, 4th Edition, requires that all PA programs must transition to a graduate degree program.[3] As a result, it isn't apparent to us that PAs and NPs differ significantly in length of time required for credentialing, and PAs certainly don't specialize during school; therefore, I feel that other factors must be at play in explaining the difference in workforce expansion noted by the authors.

Despite the fact that PAs don't specialize or have a residency during PA school, there is indeed a specialty program in dermatology for physician assistants that was omitted from the table. The Society of Dermatology Physician Assistants (SDPA) offers a "diplomate" program that was designed with leading dermatology physicians and physician assistants as a post graduation specialty program. It consists of 10 modules covering a wide range of dermatology-related topics. Upon successful completion of the program, the PA will be awarded the title of "SDPA Diplomate".[4]

Another point of potential confusion from the Hanna et al. article lies in the discussion of licensing. The article states that, "Both NPs and PAs alike have to pass their respective boards...NPs are governed by the board of nursing versus the board of healing arts." In all 50 states plus the territories, all PAs are licensed by the same medical board that licenses doctors. In two of those states, both doctors and PAs are licensed by a medical board that uses the term "healing arts" in its title. Thus, while NPs are licensed by a board of nursing, PAs are licensed by the physicians' medical licensing board.

Elsewhere, the article says, "In many states, NPs have independent practice privileges, while physician assistants do not have standardized requirements regarding physician supervision." Unfortunately, this statement seems to suggest that PAs practice under a confusing hodgepodge of rules and regulations. In reality, while it is true that the rules for PA supervision vary from state to state depending on what each state's medical licensing board has decided, the requirements within a state are often very exhaustive and specific. Physician supervision requirements vary from state to state, just as licensing procedures for doctors vary from state to state, but the regulation of the PA-doctor relationship is very well defined in each. Along the same lines, the article points out that NPs are independent practitioners, not requiring physician supervision. However, it goes on to state that, "Physician assistants have a license that is dependent or tethered to a physician license, whereas NPs' are not. NPs have their own malpractice insurance, license, and DEA and NPI numbers, prescribing abilities are dependent on individual state status." While a physician assistant's scope of practice is tied to their supervising physician, physician assistant licenses are not. In addition, PAs also have their own malpractice insurance, and DEA and NPI numbers.

Precisely defined terms allow for more informed discussions, and obviously Hanna et al.'s intention was to more clearly define both physician assistants and nurse practitioners. Here, I have tried to contribute to that process by offering corrections and clarifications to their article. Both NPs and PAs offer increased patient access to highly trained medical care. But, as indicated in Hanna et al., their roles, abilities, and limitations are not always clearly defined nor well understood—even by members of the medical community. There are certainly some differences in the training; as pointed out in Hanna et al., PAs are trained under a "medical learning model," which is modeled after medical school, while NPs are trained under a "medical-nursing" model. Though, in practice, probably the biggest difference between the two is the increasing focus on NPs acting as independent practitioners whereas mid-level practitioners have historically been thought of as a synergistic way for a physician to increase patient access to his or her clinical services.

As medical care in the United States continues to evolve over time, it is indeed important to re-examine the definitions and roles of modern medical caregivers from time to time. Ultimately, it is in the best interest of both the patients and the medical community to have a clear understanding of the roles of the major components of medical care. Discussions such as this play an important role in achieving that goal. ■

—Vicki Roberts, PA-C
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1. http://pg2pa.org/PA_NP.html
2. PAEA 2009-2010 Annual Report
3. Accreditation Review Commission on Education for the Physician Assistant (www.arc-pa.com)
4. http://www.dermpa.org/diplomate/mission-statement

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