American Academy of Physician Assistants

PROFESSIONAL ISSUES

ISSUE BRIEF

Physician Assistant Scope of Practice

Each physician assistant's (PA's) scope of practice is defined by education and experience, state law, facility policy and physician delegation. Working as members of physician-directed teams, PAs seek and embrace a physician-delegated scope of practice. State laws allow physicians broad delegatory authority, which fosters customized team care. Educated in the medical model, PAs practice with physicians in every specialty and setting. In facilities, PAs are usually credentialed and privileged through the medical staff.

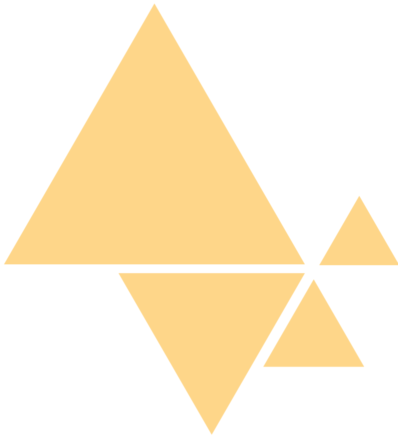
PAs are educated in the medical model and work as members of physician-directed teams. But what exactly do PAs do? And who decides?

The boundaries of each PA's scope of practice are determined by four parameters: education and experience; state law; facility policy; and the supervising physician's delegatory decisions. Each boundary must be adequately constructed in order to promote effective patient-centered care.

The PA's Education and Experience

PA scope of practice should always be limited to those tasks for which they are adequately prepared. This preparation is achieved through education and training in an accredited PA program, working with physicians in clinical practice and continuing medical education (CME).

PA education is modeled on physician education. Matriculants to PA programs must have completed at least two years of undergraduate courses in basic science and behavioral science as prerequisites to PA training. This is analogous to premedical studies required of medical students. PA programs are located at medical schools and teaching hospitals, and PA students commonly share classes, facilities and clinical rotations with medical students.



PAs seek and embrace a physician-delegated scope of practice.

PA educational training is intensive. The average length of PA education programs is about 27 months.[1] Students begin their course of study with a year of basic medical science classes (anatomy, pathophysiology, pharmacology, physical diagnosis, etc.). After the science classroom work, PA students enter the clinical phase of training. This includes classroom instruction and clinical rotations in medical and surgical specialties (family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine and psychiatry). Due to these demanding rotation requirements, PA students will have completed 2,000 hours of supervised clinical practice by the time they graduate.[2]

PAs receive a broad-based generalist education with an emphasis in primary care. And, like other health professionals, PAs continue learning in the clinical work environment and through continuing medical education. In addition to the skills learned in PA programs, PA scope of practice is determined by the fund of knowledge and clinical skills gained from working with physicians in the patient care environment and from formal CME courses. Therefore, PA scope of practice grows and shifts with advanced or specialized knowledge and with changes or advances in the medical profession overall.

State Law

The first state laws for PAs, passed in the 1970s, allowed broad delegatory authority for supervising physicians. Many laws were simple amendments to the medical practice act that allowed physicians to delegate patient care tasks within the physician's scope of practice to PAs who practiced with the physician's supervision.

In some states, though, the initial delegatory language was replaced by a more regulatory approach. Many state legislatures or licensing boards created lists of items that could be included in a PA's scope of practice. However, states soon determined that this approach was both impractical and unnecessary.

In early 1996, the North Dakota Board of Medical Examiners changed the rules governing PAs to eliminate a procedure checklist and adopt a physician-delegated scope of practice. Writing in the board's winter 1996 newsletter, *The Examiner,* 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. Furthermore, their practice is constantly evolving. This is true for individual PAs as they gain additional skill and experience and for the profession generally as medicine evolves and new practices become routine. The business of designing and maintaining a checklist which truly identified every procedure performed by every PA at any given time proved to be impossible."[3]

Although there is still some variation, most state laws have abandoned the concept that a medical board or other regulatory agency should micromanage physician-PA teams. Most state PA regulatory agencies have realized that having the board delineate scope of practice for PAs is not only inefficient, but it is also counterproductive to patient-centered care. Wyoming clearly articulates this in its regulations:

> "The board does not recognize or bestow any level of competency upon a physician assistant to carry out a specific task. Such recognition of skill is the responsibility of the supervising physician. However, a physician assistant is expected to perform with similar skill and competency and to be evaluated by the same standards as the physician in the performance of assigned duties."[4]

Facility Policy

Licensed health care facilities (hospitals, nursing homes, surgical centers and others) also have a role in determining the scope of practice for health care professionals who practice in their institutions. In general, PAs are credentialed by the medical staff and authorized through privileges

in a manner parallel to that used for physicians. Privileges are generally granted in accordance with community needs and norms. Any privileges granted by a facility, though, must conform to state law.

Delegatory Decisions Made by the Supervising Physician

To a very large extent, PA scope of practice is determined by the delegatory decisions made by the supervising physician. This allows for flexible and customized team function.

The physician has the ability to observe the PA's competency and performance and to ensure that the PA executes tasks and procedures in the manner preferred by the supervising physician. The physician is also in the best position to assess the acuity of patient problems seen in a particular setting. Within each type of medical setting, from family practice to surgical facilities, the supervising physician is able to plan for PA use in a manner that is consistent with the PA's abilities, the physician's delegatory style and the patients' needs.

The AMA recognized these concepts when its 1995 House of Delegates adopted the following Guidelines for Physician/Physician Assistant Practice:

- The physician is responsible for managing the health care of patients in all settings.
- Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
- The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- The physician is responsible for the supervision of the physician assistant in all settings.
- The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
- The physician must be available for consultation with the physician assistant at all times either in person or through telecommunication systems or other means.
- The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience and preparation of the physician assistant, as adjudged by the physician.
- Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
- The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed-upon guidelines for practice.
- The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.[5]

Conclusion

Working as members of physician-directed teams, PAs now participate in the care of patients from the neonatal intensive care unit to long-term care facilities. While PAs still work in primary care, many work in specialties, including those dealing with acute medical and surgical problems. This change has been prompted by physician demand. As PAs have become well-known, many specialist physicians have realized that PAs can help extend care to patients in almost every medical and surgical setting.

What has not changed, though, is the PA profession's commitment to team

practice, with the physician as the team leader. Since the inception of the profession, this has remained a constant. PAs seek and embrace a physician-delegated scope of practice. This is unique; no other health profession sees itself as entirely complementary to the care provided by physicians. PAs have great respect for the depth of training physicians receive and acknowledge physicians as the best-educated and most comprehensive providers on the health care team.

PAs are now found in many settings, but the role they play in physician-directed care is identical to the vision of the physicians who created the profession. The efficiency and potential for creativity found in the physician-PA team may be "just what the doctor ordered" for the challenges of health care delivery in the 21st century.

For more information about the range of specialties in which PAs work, visit *www.aapa.org/issue-briefs*.

References

[1] Physician Assistant Education Association. (2008–2009). *Twenty-fifth annual report on physician assistant educational programs in the United States*. Alexandria, VA.

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[3] Sletten R. (1996, Winter) PA Supervision Requirements. [Editorial] *The Examiner* Newsletter. North Dakota State Board of Medical Examiners.

[4] Wyoming Board of Medicine Rules and Regulations (2007). Chapter 5, Section 4d. from *http://wyomedboard.state.wy.us/BOM%20Rules%20Clean%20Nov%202007.pdf*, page 41.

[5] American Medical Association. (2009). *Physician Assistants and Nurse Practitioners*. (Policy H-160-947) from *www.ama-assn.org/ad-com/polfind/Hlth-Ethics.pdf*, page 156.

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