



1 **Title:**

2 Specialty Certification

3 **Policy Manual Section:**

4 **HP-3200.4.0 Postgraduate Education and Certification**

5 **Resolved:**

6 The AAPA opposes any NCCPA requirement that PAs must practice for an identified time in a
7 given specialty practice as a precondition for Specialty Certification.

8

9 **And further resolved:**

10 The House charges the Speaker to communicate this new policy and reason to the NCCPA.

11

12 **Justification/Rationale:**

13 In a number of policies and position papers indicated below, the AAPA has strongly opposed
14 any movement toward officially certifying PAs to particular specialty practice settings. The
15 availability of such certification would lead to the perception that such certification would of
16 necessity have a correlation with competencies. Regulators would gravitate toward requiring
17 certifications to, in theory, protect patients.

18 Certification as it exists now is an assurance that the PA-C is someone of sound moral
19 character, has graduated from an accredited institution and that they have a broad basis of training
20 that will aid them in learning the care of patients in a particular clinical setting. From this starting
21 point the PA/Physician team works for the benefit of the patients in that practice. The NCCPA has
22 a limited role as such. If the NCCPA wants to give an exam that has statistical validity for
23 assessing basic medical knowledge then they should give that exam. Yet, if they intend to
24 comment on a PA's proficiency in clinical practice – but wait 3 years to do that, then they have no
25 ethical grounds to stand on.

26 Why would a given time in a practice setting be of consequence? In reality, the PA has the
27 obligation and the ethical duty to protect the interest of the patient from their first moment of
28 employment until they are no longer working in that setting. Obviously, one cannot tolerate some
29 lower level of performance for a period of time and then suddenly be certified in that role as an
30 arbitrary measure of proficiency. Even if one sees the need to recognize a lower level of
31 proficiency soon after joining a specialty practice, the PA and supervising physician have the

32 fiduciary responsibility to safeguard patients by sequential development of clinical responsibilities.
33 As the PA and supervising physician become more comfortable in their shared practice setting, the
34 PA will gain more and more responsibility. The supervising physician is given this mandate by the
35 force of law and ethical bond with their patients.

36 Many state laws, and certainly the AAPA guidance on state law, place the burden on the
37 supervising physician to coordinate the care given to the citizens of that state. Failure to comply
38 with the standards of medical care for a Physician/PA team falls on the State Board of Medical
39 Licensure (or other bodies according to the state). Hence, the issue of whether or not someone is
40 proficient in their clinical practice is already overseen by the supervising physician and
41 certified/overseen by governmental institutions. What need would be addressed by the imposition
42 of arbitrary rules by the NCCPA? One could argue that the process of certifying specialty training
43 is not germane outside, perhaps, some academic centers.

44 The NCCPA has little to no way of correlating time in a specialty with quality of experience.
45 One year of experience at one hospital may be vastly different than at another facility. Similarly,
46 what tasks one PA performs in a specialty at one facility may be vastly different than his/her
47 counterpart at another facility. These uncontrollable variables in types and quality of practice
48 experiences reduce the requirement of time as a component of Specialty Certification to nothing
49 more than an arbitrary figure.

50 PA training by design requires students to adapt to new clinical environments on a monthly
51 basis in the terminal year of training. Thus, PAs are trained to learn diagnosis and management of
52 patients in many specialty areas. Life-long learning and adapting to new practice realities are core
53 values to the PA Profession as outline in the Guide to Ethical Conduct; this is at the core of AAPA
54 Policy. The profession, PAs, patients, doctors and regulators would not be well served by requiring
55 an on-the-job prerequisite for Specialty Certification.

56 The addition of a particular time in a specialty practice would limit the portability of
57 experienced PAs and new PA graduates. It also creates the horns of a dilemma. Administrators
58 and employers would limit PAs from becoming credentialed in institutions where regulators and
59 administrators would point to Specialty Certification as a minimal criterion. Yet, one could not sit
60 for Specialty Certification without first practicing in that specialty setting. Thus, only those
61 Specialty Certified can be credentialed in the specialty setting and only those credentialed can sit
62 for Specialty Certification. This is an unending circle from which only those already practicing in
63 the specialty can exit to be credentialed or by the proposed rule - Certified.

64 The profession is obviously against the imposition of specialty standards by the NCCPA. Any
65 proposal to additionally impose a time-in-practice requirement would have an unwanted impact on
66 new graduates moving into a practice setting; this when access to medical care is a much sought
67 after commodity. Any organization dedicated to PA practice or to the core values of the PA
68 profession should not impose any unneeded requirements that would make access to quality care
69 more difficult. The profession is on record as placing a value on portability and versatility. The
70 NCCPA would be imposing itself between patients that need specialty care and those PAs that
71 might seek to join a particular practice setting. This issue has to be brought forcefully to the
72 NCCPA.

73 **Relevant AAPA Policy:**

74 **HP-3200.4.0 Postgraduate Education and Certification**

75 **HP-3200.4.1**

76 **[Maintaining Professional Flexibility: The Case Against Accreditation of Postgraduate PA](#)**
77 **[Programs](#)**

78 (PP tab 2) [Adopted 2005]

79 **HP-3200.4.2**

- 80 • AAPA is opposed to specialty certification and to the use of specialty examinations that could
81 reduce the profession's versatility and flexibility and drastically alter its value to society.
- 82 • AAPA supports efforts by the NCCPA to explore focused, practice-specific modules, provided
83 that recertification remains generic.
- 84 • Every effort must be made to prevent regulators, employers, third-party payers, and others,
85 including PAs - from misusing the exam results.

86 **[Flexibility as a Hallmark of the PA Profession: The Case Against Specialty Certification](#)** (PP tab
87 20) [Adopted 2002 and reaffirmed 2007]

88 **HP-3500.3.4**

89 **[Guidelines for State Regulation of Physician Assistants](#)** (PP tab 5) [Adopted 1988, amended
90 1993, 1998, 2001, 2005, 2006, and 2009]

91 **HP-3500.3.5**

92 **[Guidelines for Privileging Physician Assistants](#)** (PP tab 30) [Adopted 2005]

93 **HP-3500.00 PROFESSION – REGULATION/CERTIFICATION**

94 **HP-3500.1.0 General**

95 **HP-3500.1.1**

96 AAPA believes the integrity of physician assistant credentials should be assured through a
97 credentialing process.

98 Credentialing is a process for validating the background and assessing the qualifications of health
99 care professionals to provide health care services in a variety of patient care settings. Privileges
100 granted to PAs should be consistent with state laws and regulations and hospital bylaws. *[Adopted*
101 *1999, reaffirmed 2004, amended 2009]*

102 **HP-3500.1.2**

103 American Academy of Physician Assistants recognizes that federally employed physician
104 assistants are exempt from state licensing laws and regulations of the states regarding licensure and
105 are subject to federal employment criteria established by their federal agencies or by Congress.

106 The Academy therefore believes that federally-employed physician assistants should not be
107 required to have a state license as a condition of employment, to obtain full practice privileges
108 (including prescribing), to be credentialed in a federal facility, or to participate in a federal activity
109 such as a disaster medical team. These federal employment credentials include graduation from a
110 physician assistant program accredited by the Accreditation Review Commission on Education for
111 the Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on Allied
112 Health Education and Accreditation (CAHEA), or the Commission on Accreditation of Allied
113 Health Education Programs [CAAHEP]), and/or passage of the Physician Assistant National
114 Certifying Examination (PANCE) administered by the National Commission on Certification of
115 Physician Assistants (NCCPA) and continual maintenance of national certification. *[Adopted 1996,*
116 *amended 2001 and 2003, reaffirmed 2008]*

117

118 **Possible Negative Implications:**

119 Pressure on the NCCPA to act contrary to its current inclinations.

120 **Financial Impact:**

121 None

122 **Signature:**

123 

124 Theresa Gavula, PA-C

125 President, OAPA, 2010