


What's the difference between PAs and NPs?

Tammy Ream, PA-C, MPAS; Nancy Hughes

Any PA student or practicing PA has undoubtedly been asked the question, "What is the difference between a PA and a nurse practitioner (NP)?" There is no easy way to respond because what a PA or an NP does varies by state, specialty, and individual practice. The AAPA Public Relations Committee decided to handle such a question with a list of helpful resources. Our intent was not to make PAs experts on the NP profession but rather to inform PAs on where to find accurate information. In May, we presented the information at the AAPA Annual Conference in San Francisco; this editorial, along with the accompanying sidebar, available on the Web, offers an overview of what we learned.

PAs, working with a variety of health professionals, must understand the roles of all members of the team. Both PAs and NPs provide patient care, preventive care, and health promotion. However, as one NP writer put it, "Although NPs and PAs do similar things, we do these things in our own way, with a unique philosophy."[1]

Loretta Ford, RN, EdD, considered the "mother" of the NP profession, has said, "Although confusion still exists, the NP role is not a medical one—we are not physician assistants or extenders, nor do we offer medical services at the MD's command."[2]

So what is the difference between PAs and NPs? The basic differences lie in the areas of education, regulation, and the relationship with physicians.

Education

There are more than 300 NP programs; within those programs there are specialty tracks such as family health, pediatric health, and adult health.[3] It is the policy of the American College of Nurse Practitioners that "nurse practitioner education must be specific to an area of practice" of nursing.[4] While NPs are trained in a specialty area, they may choose to work in a related subspecialty field. For example, an NP could be certified as an adult health NP or a family health NP. However, with on-the-job clinical training and continuing education, the NP's area of expertise could be nephrology.[5] A recent addition to NP education is the Doctor of Nursing Practice (DNP) degree, which stresses clinical practice and leadership growth. The American Association of Colleges of Nursing's Web site lists 22 active DNP programs.[6]

In the PA profession, there are 136 accredited PA programs, and 75% award a master's degree.[7] All students receive a general medical education, and all programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant.[8] PA education focuses on the competency of the graduate to practice medicine rather than on the degree awarded.

Regulation

The nursing literature defines NP regulation in two ways: in some states, the Board of Nursing has sole authority, and in others, physician involvement is necessary for practice. In 45 states and the District of Columbia, the Board of Nursing has sole authority in determining scope of practice for NPs; in five states, the authority is shared with the Board of Medicine. However, in 37 states, physician involvement is required in order for the NP to practice to the fullest extent, such as prescribing medications.[9] In 2005, 43 states and the District of Columbia required NPs to be nationally certified by one of four different bodies for purposes of licensure.[10]

In all 50 states, DC, and the US territories, PAs work with physician supervision. PAs are licensed by the state medical licensing board, the PA-specific component of the medical board, or a separate PA board.[11] All states and the District of Columbia require PAs to pass the Physician Assistant National Certification Examination administered by the National Commission on Certification of Physician Assistants as a condition for licensure.[12]

Relationship with physicians

Most PAs and NPs work at group or solo-physician practices.[13,14] A sample survey by the American Academy of Nurse Practitioners shows that the most common

Tammy Ream is Coordinator of Clinical Education and Assistant Professor, Texas Tech University Health Sciences Center Physician Assistant Program, and Immediate Past Chair, AAPA Public Relations Committee. Nancy Hughes is Vice President, Communications and Information Services, AAPA.

specialties for NPs are family health, adult health, women's health, pediatric health, and geriatric health.[15] The most common specialty areas for PAs are family/general medicine, surgical subspecialties, internal medicine subspecialties, emergency medicine, and general internal medicine.[14]

In 2004, 62% of NPs in all specialties reported seeing approximately 3 to 4 patients in an hour, and 27% reported seeing 1 to 2 patients an hour.[16] Twenty-seven percent reported they take call. Seventy-one percent of the NPs reported having a physician available on site between 45% and 100% of the time.[17]

The typical PA who sees inpatients exclusively had a mean of 67 patient encounters a week in 2005. The typical PA who sees outpatients exclusively reported a mean of 96 patient encounters a week. In addition, 40% of all PA respondents to the 2005 AAPA Census Survey take call and average 96 call hours per month.[14]

While PAs embrace the physician-PA team concept and physician supervision, NPs generally use the term "collaboration," meaning a close working relationship between different professions. That said, NPs do view themselves as part of an interdisciplinary health care team. As one NP editorial writer stated, "Early in the NP movement, NPs who were self-employed were said to be in independent practice. This term was never properly defined and led to much confusion and animosity . . . No one on that [interdisciplinary] team functions independently."[18]

How that team functions is determined by state law and the individual practice or hospital. For example, both the American Medical Association and the Joint Commission on Accreditation of Healthcare Organizations have considered the chart co-signature issue.[19] They have opted for allowing the physician, PA, and institution to craft a system at the practice level that is best for the patients.

Appropriate supervision results in efficient physician oversight and direction, excellence in the care provided by physician-PA teams, and good use of everyone's time. It also takes into consideration the ability of PAs to make autonomous decisions concerning the care of the patient. Physicians rely on PAs to appropriately provide medical care within their knowledge and experience; PAs rely on physicians to be available when a case requires the physician's unique skills. Of course, within this special relationship, PAs exercise autonomy in medical decision-making and provide a broad range of diagnostic and therapeutic services.[20]

Conclusion

Nearly 47 million people in this country lack adequate health insurance.[21] The average age of the population also is increasing, and older people place greater demands on the health care system. Restrictions on resident work hours went into effect in 2003. However, hospitals still need providers to meet patient demand. Legislators and policy makers seek solutions to improve access to care, and PAs have proven themselves to be a cost-effective way to enhance health care services.

CNN and *Money* magazine have proclaimed the PA profession one of the top ten jobs in the country, and the Bureau of Labor Statistics projects it will be the fourth fastest-growing profession between 2004 and 2014.[22,23] But it will take more than PAs for the health care system to accommodate growing demands. It will take a respected team of providers—with different skills, different methods of providing care, and different philosophies, but the same commitment to helping patients.

As members of the health care family, PAs and NPs aren't better or worse than one another. They're just different. They and various other providers are all needed to enhance the delivery of care. □

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