REPORT 14 OF THE BOARD OF TRUSTEES (A-24)
Physician Assistant and Nurse Practitioner Movement Between Specialties (Resolution 239)
Reference Committee B

EXECUTIVE SUMMARY

While physicians receive extensive training in a chosen specialty during their medical residency, nurse practitioners and physician assistants do not specialize in a comparable way. Both nurse practitioners and physician assistants must graduate from an accredited program and pass a certification examination for licensure in most states. While didactic education and clinical training differs between the two professions, the education of both nurse practitioners and physician assistants is broadly focused, especially compared to that of a physician. Any focus on a specific specialty in formal training is limited. While some nurse practitioners and physician assistants may "specialize" by gaining certifications in a certain area, these additional certifications are earned by acquiring experience "on-the-job," are optional upon completion of their formal training, and are separate from the initial certifications typically attained upon graduation.

Nurse practitioner programs do prepare students to provide care to a particular population as determined by the population focus selected by the students. Students choose one of six population foci—for example, family/individual, pediatrics, or psychiatric/mental health—to emphasize in their training. The chosen population focus typically determines the certification a nurse practitioner attains following graduation. As such, nurse practitioner programs vary based on the nurse practitioner's chosen population foci and the primary certification they plan to attain. Importantly, however, the education around the population focus does not rise to the level of specialty training. Specialty training represents a "much more focused area of preparation and practice than does the APRN role/population focus level."[i]

On the other hand, physician assistant programs intentionally train physician assistants as "generalists," not specialists. The physician assistant curriculum is largely the same for all physician assistant students. However, physician assistants can obtain Certificates of Added Qualifications (CAQs) post-graduation in certain specialties such as cardiovascular and thoracic surgery or emergency medicine. These CAQs are optional and require physician assistants to acquire work hours in the relevant specialty. Of note, CAQs are separate from the PA-C certification, which is the single certification offered to physician assistants who have graduated from an accredited program and passed the Physician Assistant National Certifying Examination.

A nurse practitioner or physician assistant's certification is not always aligned with the specialty or setting in which they practice during their career. In fact, both can move between specialties throughout their career often with little to no additional education or training. Available data shows that an increasing number of nurse practitioners and physician assistants are practicing in specialties outside of primary care. However, there is no publicly available data on how often nurse practitioners change specialties and very little such data on physician assistants. Nevertheless, the flexibility to move between specialties is often touted as a "selling point" for prospective students.

This Board Report provides a summary of the underlying education and training of nurse practitioners and physician assistants, as well as an overview of initial certifications and optional specialty certifications available to each profession. The report also examines existing workforce studies and data on specialties and practice settings of nurse practitioners and physician assistants and the alignment of such to the certification of the respective nurse practitioner or physician assistant.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-24

Subject: Physician Assistant and Nurse Practitioner Movement Between Specialties

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Resolution 239 entitled, "Physician Assistant and Nurse Practitioner Movement Between Specialties." This resolution asked the AMA to study the movement of nonphysician health care professionals between specialties.

Procedural History

Resolution 239 was introduced by the Arizona delegation and asked:

> That our American Medical Association Board of Trustees study and report back at the 2023 Interim meeting on the economic impact to primary care and other lower tier income medical specialties of specialty switching by Advanced Practice Providers (Directive to Take Action); and
>
> That our AMA Board of Trustees study and report back at the 2023 Interim meeting about possible options on how APP's can best be obligated to stay in a specialty tract that is tied to the specialty area of their supervising physician in much the same way their supervisory physicians are tied to their own specialty, with an intent for the study to look at how the house of medicine can create functional barriers that begin to make specialty switching by Advanced Practice Providers appropriately demanding. (Directive to Take Action)

Similar in intent, Resolution 262 was introduced by the Private Practice Physicians Section and asked:

> That our American Medical Association create a national task force that will make recommendations for the best process for advanced practice providers (APPs) to develop specialty designations or an associated apprenticeship process that is parallel to the specialties of the physicians that supervise them (Directive to Take Action);
>
> That our American Medical Association study and report back at Interim 2023 on the economic impact to medical practices of specialty switching by advanced practice providers (Directive to Take Action); and

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> That our American Medical Association study and report back at the 2023 Interim Meeting about possible options on how advanced practice providers can best be obligated to stay in a specialty tract (Directive to Take Action).

Testimony on both of these Resolutions was limited. The Reference Committee heard that the AMA does not have the authority or purview over post-graduate clinical training requirements of nonphysicians and that the AMA has extensive resources detailing the education and training of nurse practitioners and physician assistants. However, the Reference Committee also heard testimony indicating that a growing number of nonphysicians are moving between specialties, and that this is a concern for physicians.

Seeking to meet the underlying concerns raised in Resolutions 239 and 262, the Reference Committee recommended that Resolution 239 be adopted with an amendment, and that the amended Resolution 239 be adopted in lieu of Resolution 262. The HOD agreed and ultimately adopted amended Resolution 239, which reads as follows:

> That our American Medical Association study the movement of nonphysician health care professionals such as physician assistants and nurse practitioners between specialties.

This Board of Trustees Report aims to address this directive. It examines the educational preparation of nurse practitioners and physician assistants and evaluates their ability to move between specialties.

BACKGROUND

The implications of specialty switching by nurse practitioners and physician assistants are best understood when one considers the underlying education, training, and certification of each profession.

Nurse Practitioner Education and Training

Nurse practitioners are one type of Advanced Practice Registered Nurse (APRN). While the focus of this board report is on nurse practitioner and physician assistant certification, the foundational documents for nurse practitioner education include APRNs in four types of "roles:" nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists (CRNAs). Each type of APRN has its own accreditation and certifying bodies. For example, CRNA programs are accredited by the Council on Accreditation of Nurse Anesthesia Education Programs (COA) and CRNAs can obtain certification from the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA). By contrast, the Commission on Collegiate Nursing Education (CCNE) and the Accreditation Commission for Education in Nursing (ACEN) both accredit nurse practitioner programs, and nurse practitioners may be certified by one of several different certifying bodies.

APRN education and training is based on foundational documents that were drafted and agreed to by leaders in the nursing profession:

- Two American Association of Colleges of Nursing (AACN) "Essentials" documents: *The Essentials of Master's Education in Nursing (2011)* and *The Essentials of Doctoral Education for Advanced Nursing Practice (2006)* (together, the *AACN Essentials*).

- The National Task Force on Quality Nurse Practitioner Education's *2016 Criteria for Evaluation of Nurse Practitioner Programs* (*NTF Standards*).
- The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education (APRN Consensus Model).

Taken together, these documents provide the framework for the curriculum and accreditation of nurse practitioner graduate education programs.

What is referred to as the "APRN Consensus Model" also provides a model for APRN regulation and certification. The APRN Consensus Model is the basis for the four distinct roles of APRNs and the six-population foci that are foundational to APRN education and training:

- Family/individual across the lifespan;
- Adult-gerontology;
- Pediatrics;
- Neonatal;
- Women's health/gender-related; and
- Psychiatric/mental health.

A nurse practitioner's specific educational experience will depend on their chosen population focus, and so will their certification. The APRN Consensus Model states that, "[e]ducation, certification, and licensure of an individual must be congruent in terms of role and population foci."[ii] As such, distinct certifications—which are generally required for licensure—were created for each population focus, and in some cases for primary care as distinct from acute care. Each certification is aligned with a different educational track. In short, it is expected that a nurse practitioner's education and training will be based on the certification they plan to attain after graduation. Consequentially, nurse practitioner programs vary slightly based on the nurse practitioner's chosen population foci and the certification they plan to attain. Each certification has a somewhat different educational pathway, but all nurse practitioners must meet the same core academic requirements. The APRN Consensus Model provides the required "APRN core" courses included in the curriculum for all nurse practitioners (and all APRNs):

- Physiology/pathophysiology;
- Health assessment; and
- Pharmacology.[iii]

Specialty training, by contrast, represents a "much more focused area of preparation and practice than does the APRN role/population focus level."[iv]

Across all population foci, nurse practitioner clinical training requirements are largely not standardized, in sharp contrast to physician clerkships and residencies. Nurse practitioners only undergo 500-750 hours of clinical training. This results in evident experience gaps. For example, even though some of the nurse practitioner certifications broadly span patient populations, including across the lifespan from children to geriatric patients, studies on nurse practitioner education have documented that family nurse practitioners (FNPs) often receive minimal training across patient populations.

Notably, a study in the *Journal of Nursing Regulation* surveyed recent FNP graduates on how often they performed basic tasks like prescribing medications, obtaining a health history, ordering

diagnostic tests, and developing differential diagnoses during their entire training.[v] The survey also examined these tasks across patient populations, providing a window into how the FNP education and training prepares students for practice. The results were shocking. For example, only 61.5 percent of FNPs reported they prescribed medications to an adult patient more than 10 times, 15 percent said they only prescribed medications to an adult patient one to two times.[vi] The numbers were even lower for pediatric and geriatric patients. Only 44.6 percent and 56.3 percent of FNP students surveyed said they prescribed medications more than 10 times to a pediatric patient and geriatric patient respectively, with 5.5 percent and 4.0 percent of FNP students indicating they *never* prescribed medications to pediatric or geriatric patients respectively during their clinical training.[vii] This study demonstrates the lack of standardization in nurse practitioner training programs. Yet, FNPs often practice across patient populations and increasingly in specialties outside primary care.

Nurse Practitioner Certification

For initial certification of nurse practitioners, two major certifying bodies exist: the American Academy of Nurse Practitioners Certification Board (AANPCB) and the American Nurses Credentialing Center (ANCC).[viii] Each certifying body administers their own examination and offers their own certifications. Both AANPCB and ANCC require nurse practitioners to renew their certification every five years. Most states require certification for licensure as a nurse practitioner, and certification exams are generally aligned with population foci.

The AANPCB offers three initial certifications: Family Nurse Practitioner (FNP), Adult-Gerontology Primary Care Nurse Practitioner (A-GNP), and Psychiatric Mental Health Nurse Practitioner (PMHNP).[ix] AANPCB's FNP examination is an online examination with 150 multiple choice questions, which must be completed in three-hours. In 2021 the pass rate was 84 percent. AANPCB has retired a couple of certifications, including the Adult Nurse Practitioner (retired in 2017) and Gerontology Nurse Practitioner (retired in 2012). Nurse practitioners who obtained these retired certifications can maintain the credential as long as they continue to renew their certification by completing the required clinical practice hours and continuing education.

ANCC offers four certifications for nurse practitioners: Family Nurse Practitioner (FNP-BC), Adult-Gerontology Primary Care Nurse Practitioner (AGPCNP-BC), Adult-Gerontology Acute Care Nurse Practitioner (AGACNP-BC), and Psychiatric Mental Health Nurse Practitioner (PMHNP-BC). ANCC's FNP-BC certifying examination includes 150-200 questions that vary in format from multiple choice, drop and drag, and multiple response. The average pass rate in 2021 was 87 percent. ANCC also offers certifications for registered nurses, as well as micro-credentials in certain sub-specialties. ANCC has also retired several certifications, including Acute Care Nurse Practitioner, Adult Nurse Practitioner, Adult-Psychiatric Mental Health Nurse Practitioner, Emergency Nurse Practitioner, Gerontological Nurse Practitioner, Pediatric Primary Care Nurse Practitioner, and School Nurse Practitioner. Like the retired certifications offered by AANPCB, nurse practitioners may renew these ANCC retired certifications to maintain their credential.[x]

	American Academy of Nurse Practitioners Certification Board (AANPCB)	American Nurses Credentialing Center (ANCC)
Current certifications	Family Nurse Practitioner (FNP) Adult-Gerontology Primary Care Nurse Practitioner (A-GNP) Psychiatric Mental Health Nurse Practitioner (PMHNP)	Family Nurse Practitioner (FNP-BC) Adult-Gerontology Primary Care Nurse Practitioner (AGPCNP-BC) Adult-Gerontology Acute Care Nurse Practitioner (AGACNP-BC) Psychiatric Mental Health Nurse Practitioner (PMHNP-BC)
Retired certifications	Adult NP (retired) Gerontology NP (retired)	Acute Care NP (retired) Adult NP (retired) Adult-Psychiatric Mental Health NP (retired) Emergency NP (retired) Gerontological NP (retired) Pediatric Primary Care NP (retired) School NP (retired)

While AANPCB and ANCC are the largest certifying bodies for nurse practitioners, other smaller certification bodies exist, including the American Association of Critical-Care Nurses (AACN), National Certification Corporation (NCC), Pediatric Certification Board (PNCB), Certification Board for Urological Nurses & Associates (CBUNA), and Hospice & Palliative Credentialing Center (HPCC).

Nurse Practitioner Specialties

Under the APRN Consensus Model, advanced practice registered nurses are licensed at the level of the population focus—not at the specialty level.[xi] Advanced practice registered nurses cannot be licensed solely within a specialty area.[xii] Regarding specialties, the APRN Consensus Model notes that specialties are optional but <u>must</u> be congruent with and build on the individual's established role and population foci.

Nurse practitioners may pursue optional certification in various specialties/subspecialties after initial certification in their role and population focus. An array of certifying boards issue "specialty" certifications for nurse practitioners—typically these certifications are based on hours of practice experience in a specialty and passage of an exam. Customarily, the certifying boards are specific to nursing and specific to a single specialty. For example, the Orthopaedic Nurses Certification Board certifies nurse practitioners in the orthopaedic specialty (ONP-C) and the Dermatology Nurses Association certifies dermatology nurse practitioners (DCNPs). However, AANPCB offers an Emergency Nurse Practitioner (ENP) certification for certified FNPs with specialty education and practice in emergency care.

Note that specialty certification is generally not required for practice within a given specialty—indeed, work within a specific specialty is required to earn specialty certification.

Nurse Practitioner Workforce

Nurse practitioners are not required to practice within the specialty in which they are certified, and so there is great misalignment between nurse practitioner certification and the setting or specialty in which they practice. The APRN Consensus Model attempts to align the nurse practitioner curriculum with the certification a nurse practitioner can attain after graduation, however, a nurse

practitioner's certification is not always congruent with the specialty or setting in which the nurse practitioner practices during their career. Myriad data sources confirm this misalignment. For example, the American Association of Nurse Practitioners (AANP) claims that 88 percent of nurse practitioners are certified in primary care, but also reports that only 70.3 percent of nurse practitioners deliver primary care. The most recent Health Resources and Services Administration (HRSA) workforce data suggests a greater disparity, reflecting that only 24 percent of nurse practitioners deliver primary care.[xiii]

HRSA's findings are consistent with several state-level workforce studies, including the following:

- A study from the Oregon Center for Nursing examined the number of nurse practitioners practicing in primary compared to specialty care in Oregon. Looking at practice setting and area of practice, data from the survey revealed that only one-third of nurse practitioners practice in primary care and about 22 percent provided a combination of primary and specialty care. Of those nurse practitioners providing both primary and specialty care, about 62 percent spent less than half of their time focusing on primary care.[xiv] The study found that the gap between nurse practitioners providing primary care versus specialty care is widening over time, with a greater number of nurse practitioners providing specialty care and fewer nurse practitioners providing primary care. It concluded that certification alone is not enough to determine one's area of practice.
- Adding to this body of evidence is *A Profile of New York State Nurse Practitioners, 2017*, a workforce report in which only about *one-third* of actively practicing nurse practitioners were considered primary care nurse practitioners based on their specialty certification and practice setting, even though a vast majority of nurse practitioners in the state report a primary care specialty certification. To indicate, 87 percent of nurse practitioners reported a certification in primary care (36.8 percent in family health, 23.2 percent in adult health, 8.1 percent in pediatrics). [xv]
- A *2023 South Dakota Workforce Study* had similar findings.[xvi] Based on data gathered from nurse license renewal applications, including nurses who renewed their license, reactivated an inactive license, or reinstated a lapsed license, 80.9 percent indicated they were licensed and certified as family nurse practitioners yet only 24.9 percent identified "family health" as their primary area of specialty, 5.1 percent chose "primary care", and 6 percent chose adult health.[xvii] Other notable specialties selected include "other" (11.6 percent), psychiatric/mental health/substance abuse (8.2 percent), acute/critical care (7.3 percent), cardiology (4.2 percent), and emergency/trauma (3.5 percent).[xviii]

Studies also elucidate lack of congruence between nurse practitioners' certification and their practice in acute care settings.[xix] As noted earlier, some certifications distinguish between primary and acute care—and this distinction is ostensibly reflected in the nurse practitioner's educational track. Yet, many nurse practitioners are certified in primary care work in an acute care practice specialty or setting.

A study published in *Nursing Outlook* using data from HRSA's 2018 National Sample Survey of Registered Nurses found that among nurse practitioners working in acute care settings, only 44.5 percent held a certification in acute care, while 55.5 percent held only a primary care certification (13.7 percent held both acute care and primary care certifications). Notably, only about half of nurse practitioners working in acute care reported that they feel prepared to be an independent practitioner.[xx]

1 Below are findings by clinical specialty area in which the respondents worked:

	Acute Care Certified (N = 8,256)	Primary Care Certified (N = 10,297)
Total	44.5%	55.5%
Clinical Specialty		
General medical surgical	27.5%	37.6%
Critical care	23.5%	25.3%
Chronic Care	30.0%	10.6%
Neurological	6.4%	7.0%
Oncology	5.0%	9.2%
Other	7.6%	10.3%

*from Nursing Outlook $p < .01$

2 These findings were consistent with other studies examining the misalignment between nurse
3 practitioners' credentials and their practice setting. For example, using data from the AANP
4 National Nurse Practitioner Sample Survey, researchers found that of the 366 nurse practitioners
5 who responded they were a hospitalist caring for adult patients (i.e., in an acute care setting),
6 74.7 percent were certified in primary care—with a full 75 percent indicating "on-the-job training"
7 as their qualification to be a nurse practitioner hospitalist.[xxi]
8
9 Similarly, while emergency departments are for acute-life or limb threatening emergencies and
10 providing care to critically ill patients, most nurse practitioners working in emergency departments
11 are certified as an FNP. In fact, while there is a separate specialty certification for emergency nurse
12 practitioners (ENPs), only FNPs are eligible for such certification—not acute care nurse
13 practitioners, even though emergency departments are acute care settings. Moreover, 90 percent of
14 nurse practitioners practicing in emergency departments do not have the ENP additional specialty
15 certification.[xxii]
16
17 Altogether, education and certification are not determinative of where a nurse practitioner will
18 practice—workforce studies show that nurse practitioners commonly practice in clinical settings or
19 specialties that are misaligned with, their education, training, and credentials.
20
21 *Specialty Switching by Nurse Practitioners*
22
23 Nurse practitioners may switch specialties throughout their career with few limitations, with the
24 primary limitation being that, per the APRN Consensus Model, a nurse practitioner's specialty
25 must align with the population focus of the nurse practitioner's training, as well as their
26 certification. For some nurse practitioners this provides broad latitude in mid-career changes. For
27 example, FNPs are trained to provide primary care across the lifespan and so would qualify for a
28 broad range of specialties. By contrast, an adult-gerontology primary care nurse practitioner (AG-
29 PCNP) might be more limited. For example, an AG-PCNP would likely have to complete
30 additional training to care for children, or to care for adult or geriatric patients outside primary
31 care.[xxiii]
32
33 *Physician Assistant Education and Training*
34
35 Physician assistant programs are accredited by the Accreditation Review Commission on
36 Education for the Physician Assistant (ARC-PA) and are two-to-three years in length. Physician

assistant programs provide a generalist education rather than focus on a particular specialty.[xxiv] Per the standards, program curriculum must include, "applied medical, behavioral and social sciences; patient assessment and clinical medicine; *supervised clinical practice*; and health policy and professional practice issues."[xxv] Upon completion of the program graduates are awarded a master's degree and become eligible to sit for the physician assistant certification examination.

Physician Assistant Certification

A single body certifies physician assistants: the National Commission on Certification of Physician Assistants (NCCPA). Certification is available to physician assistants who graduate from an ARC-PA accredited program and pass the Physician Assistant National Certifying Examination. Physician assistants are eligible to take the examination up to six-years after graduation and those who pass are awarded the PA-C credential. To maintain certification, physician assistants must complete a minimum number of hours of continuing medical education (CME) and pass the Physician Assistant National Recertifying Examination (PANRE) every 10 years. Most states require completion of a minimum number of hours of CME, current certification by NCCPA, or both as a condition of licensure or for licensure renewal.

The single certification for physician assistants is consistent with the approach for physician assistant education and training—to provide a generalist education without a focus on specialty. This is evident in both the didactic curriculum and clinical training of physician assistants. For example, the 2,000 hours of clinical practice required of physician assistants includes rotations in various specialties, including emergency medicine, obstetrics and gynecology, psychiatry, family medicine, and internal medicine. Standards also include requirements that these clinical rotations must include specific types of encounters. For example, physician assistant students must treat patients requiring chronic, acute, emergent, and preventive care and must also provide care in a variety of settings, including the emergency department, outpatient, and inpatient facilities. There is no path for specialized focus in the physician assistant educational program.

In addition to the PA-C certification, NCCPA also offers optional specialty Certificates of Added Qualification (CAQs) to physician assistants in 10 specialties, including:

- Cardiovascular & Thoracic Surgery;
- Dermatology;
- Emergency Medicine;
- Hospital Medicine;
- Nephrology;
- Obstetrics and Gynecology;
- Orthopaedic Surgery;
- Palliative Medicine and Hospice Care;
- Pediatrics; and
- Psychiatry.[xxvi]

A physician assistant who has acquired a CAQ is considered "board certified." The specific requirements vary by specialty but generally require the following: (1) completion of specialty-specific CME, (2) attestation that the physician assistant has completed a certain number of hours of experience in the specialty, (3) attestation that the physician assistant has the knowledge and skills relevant to practice in the specialty, including the knowledge and skills to perform the procedures relevant to the specialty, and/or that the physician assistant understands how and when

1 the knowledge and skills should be applied for appropriate patient management or how and when
2 the procedures should be performed, and (4) achieve a passing score on a specialty examination
3 (online or in person).
4
5 CAQs often rely heavily on attestations and may not actually require the physician assistant to
6 complete relevant procedures. Consider as an example the requirements to attain a CAQ in
7 emergency medicine:
8
9 - Self-attest to completing 75 credits of Category 1 CME focused on emergency medicine;
10 25 of which must be earned within two-years of the date of the application for the specialty
11 examination and the remaining earned within six years before this date.
12 - Complete a comprehensive emergency medicine course that reflects the guidelines set forth
13 in the most current version of Model of the Clinical Practice of Emergency Medicine, and
14 complete the following courses:
15   - Pediatric Advanced Life Support or Advanced Pediatric Life Support
16   - Advanced Trauma Life Support
17   - Airway course
18 - Self-attest to completing 3,000 hours of experience working as a physician assistant in
19 emergency medicine within at least six-years.
20 - Obtain attestation from a physician, lead/senior physician assistant, or physician/physician
21 assistant post graduate program director who works in emergency medicine and is familiar
22 with the physician assistant's practice and experience. The attestation must affirm that the
23 physician assistant, "*has performed* the procedures and patient management relevant to the
24 practice setting and/or *understands* how and when the procedures *should* be
25 performed…the PA may not have experience with each procedure, but he or she must be
26 knowledgeable of the basics of the procedures, in what situation the procedures should be
27 done, and the associated management of patients."[xxvii]
28 - Pass an examination which consists of 120 multiple choice questions, which can be taken
29 at a test center or online.
30
31 CAQs are wholly optional for physician assistants and are generally not required for physician
32 assistants to practice. Indeed, before earning and in order to earn a CAQ in the first instance, a
33 physician assistant must practice in a chosen specialty.
34
35 *Physician Assistant Workforce*
36
37 According to the NCCPA 2022 statistical profile of board-certified physician assistants, only 23.1
38 percent of physician assistants work in primary care, which includes "family medicine/general
39 practice, internal medicine general, and pediatrics general." When asked to identify their primary
40 area of practice, the most physician assistants reported working in the five specialties:
41
42 - Surgical subspecialties (18.6 percent);
43 - Family medicine/general practice (17.1 percent);
44 - Emergency medicine (11.2 percent);
45 - Other (10.6 percent; *note that the most frequent responses include: urgent care,
46 interventional radiology, sleep medicine, aesthetics, trauma surgery, wound care, and
47 transplant surgery); and
48 - Internal medicine subspecialties (9.9 percent).

Most physician assistants practice in hospital settings (41.7 percent) with office-based private practice a close second (37.1 percent). Urgent care (5.6 percent) and federal government facility/hospital/unit (4.7 percent) are a distant fourth and fifth.

While most physician assistants hold one clinical position (84.9 percent), 11.3 percent of physician assistants hold two or more clinical positions, with emergency medicine (25.6 percent) being the most common secondary specialty area of these physician assistants.

Specialty Switching by Physician Assistants

Since physician assistants are trained as "generalists," they face very few barriers to specialty switching. Indeed, more than half have changed specialties at least once during their career with over 20 percent indicating they have changed specialties two to three times.[xxviii] This can be done without any additional education, formal training, or certification.

AMA POLICY

The AMA has extensive policy supporting physician-led team-based care, including policy on appropriate physician supervision of nurse practitioners and physician assistants:

- Policy H-160.949, "Practicing Medicine by Non-Physicians;"
- Policy H-160-906, "Models /Guidelines for Medical Health Care Teams;"
- Policy H-160.950, "Guidelines for Integrated Practice of Physician and Nurse Practitioner;"
- Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice;"
- Policy H-35.989, "Physician Assistants;" and
- Policy D-35.985 "Support for Physician Led, Team Based Care."

The AMA also has policy directing our AMA to educate the public on the difference in the education and training of physicians and non-physicians. Specifically:

- Policy H-160.949, "Practicing Medicine by Non-Physicians;"
- Policy H-450.955, "Education of the General Public on the Role of Physician and Non-Physician Health Care Providers;" and
- Policy H-275.943, "Public Education about Physician Qualifications."

DISCUSSION

The nurse practitioner and physician assistant professions both began with an emphasis on providing primary care to patients to help address the primary care workforce shortages. Over time, however, both nurse practitioners and physician assistants are increasingly choosing to practice in specialties instead of primary care and may switch specialties multiple times during their career. The idea of specialty switching by nurse practitioners and physician assistants is not a new phenomenon and such flexibility in specialization is often touted by both professions as a positive attribute to prospective students.

The underlying education and clinical training of both nurse practitioners and physician assistants is founded upon a generalist approach. With limited exceptions, there is no focus on specialty care.

While state licensure requires graduation from an accredited program and certification by a designated body, physician assistant certification and most nurse practitioner certifications are extremely broad, allowing wide latitude in the patient population, specialty or setting in which they can practice.

Moreover, there are little-to-no guardrails limiting the specialties in which nurse practitioners and physician assistants may work. In fact, many studies show a misalignment between nurse practitioner education, training, and certification and the specialty or setting in which they practice, such that some nurse practitioners find themselves in the position of caring for a patient population or level of acuity in which they have received no formal education or training. For both professions, on-the-job training post-graduation is a common means to gain the requisite knowledge in the specialty and practice setting in which they practice. This reinforces the importance of physician-led team-based care.

While studies demonstrate the increased number of nurse practitioners and physician assistants practicing in specialties as opposed to primary care, there is no publicly available data on specialty switching by nurse practitioners. There are also no studies on the impact of specialty switching on the cost and quality of care provided by nurse practitioners and physician assistants. Moreover, there are no studies on the additional workload placed on physicians and other health care professionals who must provide on-the-job training to nurse practitioners or physician assistants who have switched specialties and/or are practicing in a specialty in which they have no formal education, training, or certification. Moreover, there are no studies looking at the impact of specialty switching in these professions on physician burnout, nor are there studies that look at the impact on physician’s time away from providing direct patient care. These gaps in literature are ripe for analysis, particularly by those conducting research on the health care workforce. State nursing and medical boards could also capture this information as part of a survey conducted at the time of licensure renewals by nurse practitioners and physician assistants.

RECOMMENDATIONS

The Board of Trustees recommends that the following policy be adopted, and the remainder of the report be filed:

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)
3. That the AMA encourage hospitals and other health care entities employing nurse practitioners to ensure that the nurse practitioner’s certification aligns with the specialty in which they will practice. (New HOD Policy)
4. That the AMA continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[i] Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education (July 7, 2008) pg. 12.
[ii] *Id*. at 6.
[iii] *Id*. at 11.
[iv] *Id*. at 12.
[v] McNelis AM, Dreifuerst T, Beebe S, et al. Types, Frequency, and Depth of Direct Patient Care Experiences of Family Nurse Practitioner Students in the United States, *Journal of Nursing Regulation*, 2021; 12(1), 19-27.
[vi] *Id*. at 25.
[vii] *Id*.
[viii] Other certifying bodies include: the American Association of Critical-Care Nurses (offers certification to RNs and APRNs),
[ix] PMHNP is a new certification which will be available from AANPCB in January 2024.
[x] https://www.nursingworld.org/certification/aprn-consensus-model/ (last visited on Jan. 23, 2024).
[xi] *Supra* note 1 at 13.
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