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Unraveling the recertification conundrum

Reamer L. Bushardt, PharmD, PA-C, DFAAPA; Harrison Reed, MMSc, PA-C

In November 2015, the National Commission on Certification of Physician Assistants (NCCPA) proposed a new recertification model and in December released "Re-examining Recertification for the PA Profession," a white paper offering more detail and rationale for the change.[1] The paper stands on two key principles for development of the new model: concern for the public's interest and support for PA career flexibility.

The NCCPA planned to gather feedback on the proposal via a profession-wide survey in February, but at press time, some PAs had already offered reactions via social media and discussion forums, including a critical letter from AAPA President Jeffrey Katz. We want to offer commentary to point out important limitations in the information gathered thus far, appeal to PAs to take advantage of the profession-wide survey to share their opinions, and challenge readers to consider that the PA professional identity may be at the heart of this recertification conundrum.

Few would doubt that the landscape for PA practice has changed. According to a 2014 NCCPA report, 73% of certified PAs now practice in specialties outside primary care.[2] Boasting an impressive a response rate of 89% (nearly 91,000 PAs) the survey indicated that the three most common practice areas for PAs were family medicine/general practice, surgical subspecialties, and emergency medicine. These three areas represented more than half of respondents. Survey data also documented that respondents (n=61,334 for this profile item) were practicing in 27 different practice areas. With the revelation that the "generalist" PA profession no longer flocks to general practice, NCCPA leadership found cause to revisit the profession's recertification structure.

Reamer L. Bushardt is professor and chair of the Department of Physician Assistant Studies and a program leader in the Clinical Translational Science Institute at Wake Forest School of Medicine in Winston-Salem, N.C., and editor-in-chief of *JAAPA*. **Harrison Reed** practices emergency medicine at Fremont Emergency Services in Las Vegas, Nev., and is associate editor of *JAAPA*. The authors have disclosed no potential conflicts of interest, financial or otherwise.

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The NCCPA informed its proposed model with its 2015 PA practice analysis survey, a multiday PA focus group, a survey of PAs developed from focus group discussions, a survey of state medical boards, and analysis of prior performance data from recertification examinations. But clear gaps exist in the data collected thus far, like an anemic 17% response rate to the practice analysis survey, a tool intended to represent the PA population as a whole. However, NCCPA representatives tell *JAAPA* that about 8% of respondents completed the entire practice analysis portion of the survey, with response rates to any given question ranging from 8% to 17%. The aforementioned focus group discussions drew their 29 handpicked volunteers from a pool of about 900 respondents to an open solicitation for volunteers in an electronic newsletter. Finally, the NCCPA white paper acknowledges a poor response rate from its survey of state medical boards, with only 25 total respondents representing 15 states. These selections are far from comprehensive and PA participation in the profession-wide survey may be the first and only chance to solicit true broad professional response.

Of course, methodologic flaws do not equal maleficence. It would be easy to paint the NCCPA as the villain. It would be easy to mention that additional recertification examinations pour money directly into the coffers of the NCCPA itself, like an unelected government levying taxes without the vote of its constituents. It would be easy to accuse an NCCPA board comprising specialty-practicing clinicians of overrepresenting their own biases. It would be easy to dismiss a plan proposed by a board led by a physician, someone who is not affected by the very decisions her board hands down. But certifying medical practitioners cannot be easy, especially a population of PAs practicing across so many diverse settings and clinical specialties. And controversy over maintenance of certification is not an issue unique to the PA profession (see the Musings blog post, Maintenance of certification practices—a look at internists and APRNs, at www.jaapa.com).

Recent posts by PAs to discussion boards and blogs about these recertification changes express a strong sense of frustration or mistrust, in some cases even anger. But these proposed changes are not a scheme concocted by scoundrels in a hidden lair. The NCCPA board of directors is a group of volunteers; many are fellow PAs or physicians highly supportive of PA practice, who give up their time to help safeguard the quality of PA practice. These are exactly the

type of people we might want representing our interests on a national stage.

But good people can have bad ideas.

Here is something you can count on: proctored tests are the only ones that matter. The NCCPA proposes a take-home generalist examination under the new certification process, but any realistic critic knows this would become a hunt-and-search for information that establishes the test-taker's prowess in Internet searches more than clinical knowledge. For quality assurance, it might as well not exist.

That means the crux of the new proposal is a wholesale swap of the current proctored generalist examination for the proposed specialty-specific examinations. This might sound progressive at first: reflect the growing trend in medical and PA practice by embracing specialization. But this move creates more than a few problems.

PA practice differs in every setting, most of all in specialties. That heterogeneity makes an encompassing evaluation of each specialty difficult and unfair. The very division between specialties and subspecialties invites confusion. Is transplant medicine a surgical specialty, classified by the organ involved, or something else entirely? Layer on top the practice variance influenced by state-specific, facility-specific, or collaborating physician-specific paradigms, and credence is borne to the phrase, "If you've seen one PA in practice, you've seen one PA in practice."

Although the NCCPA insists the new system promotes flexibility, specialty-based examinations encumber professional mobility. Throughout a certification cycle, a PA might work in multiple specialties or move to one from a primary care setting. That eclectic experience might make for a good clinician, but makes it difficult to fit every member of a profession known for clinical mobility into a designated mold. The proposed system rewards a pick-and-stay mentality, punishes career exploration, and may hamper necessary mobility to combat the current epidemic of physician maldistribution.

The most harrowing consequence of a proposed specialty-based certification system, however, is not a loss of convenience. It is a loss of our professional identity. Advocates of specialty certification might say: "I am never leaving this neurosurgery practice. Why waste my time and energy on irrelevant medical subjects when I can focus on helping the patient in front of me?" But medicine is medicine. The patient in front of us doesn't care if our knowledge stops at the blood-brain barrier or if our professional interest is distal to the wrist. The pathology affecting the patient is naïve to our resume and uninterested in which professional conferences we attend. Although none of us will ever be an expert in every aspect of medicine, we owe it to our patients to preserve a basic understanding of the field in which we practice: medicine.

PAs are a unique group of highly trained clinicians who are licensed in general practice. As a profession we have been offered careers in nearly every medical and surgical specialty *because* we can do it all. And all 50 states have granted us a license to practice medicine with an inherent understanding that we will maintain current knowledge. At the very least, in a decade we should still be able to vanquish the hypothetical diseases on computerized examination questions.

Like the engineering of an earthquake-proof building, the flexibility of our profession makes it stronger and more durable than most. Proponents of abolishing the general recertification examination or creating mandatory specialization (both are components of the proposed NCCPA plan) wish to remove a pillar of strength from the PA profession: A pillar that promotes the value of our profession amidst turbulent changes in healthcare. **JAAPA**

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