IS THE PA STANDARD OF CARE A NATIONAL STANDARD OF CARE?

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Originally sent to Members as an Email

I am often asked by PAs who wish to do standard of care testimony whether the standard of care in their state is the same as in another state. First, it is important to understand what is meant by the standard of care for testimony purposes in most states: *It is what a reasonable and prudent PA would be expected to know or do under same or similar circumstances.* Are all PA's expected to know or act similarly in clinical situations nationwide? The simple answer is yes. The following is my answer when asked this question in depositions:
The Clinical Standard of Care (SOC) for PAs is a *NATIONAL* Standard of Care.

It has as its basis the following four facts:

1- All PA programs must adhere to a **singular curriculum** (there may be minor variation and optional extras at some programs, but all must adhere to and prove that they teach the exact same minimal required curriculum);

2- All PA programs are accredited by the **one and only accrediting body (the ARC-PA)** for PA programs;

3- PAs have only **one national certification organiozation (the NCCPA),** and

4- there is **one standardized general medicine certifying examination that all PAs must take**. (See CAQ comment at end.)

The bottom line is that we all know or at least all are expected to know the exact same body of clinical medical knowledge upon graduation from our educational programs. We are one of the most educationally consistent allied health professions. In comparison with nurse practitioners, there are numerous NP accrediting bodies, variable curricula and at least three different certifying organizations. In many cases an NP graduate may fail an exam from one nursing board and then take an exam from another.

Now what about state regulations? State regulations do vary from state to state, but state regulations do not constitute *clinical* standards of care. It's not an equal comparison. States compose the guidelines or parameters under which we are allowed to practice our clinical standard of care. You are wise to keep these distinct when giving testimony.

State regulations may come up in cases you review, but in my experience they are never central to proving negligence.

I hope most of you found this helpful. I will continue to email answers to common questions and tips as a benefit of membership.

I welcome and invite experienced APALM members and other board members to email tips to me to share as well.

Enjoy your summer. Jeff

** The optional CAQ - certificate of added qualification for many specialties is slowly adding a caveat to the question. It does not happen often, but at least one attorney has recently asked me to find him an ER PA with CAQ in emergency medicine because the PA being sued had that CAQ. I expect this will continue to happen more frequently.

Additional Commentary from APALM Board Emeritus
Peter I. Bergé, JD, MPA, PA-C

The excellent reasoning provided above for this explanation is very similar to the answer that I gave when I was deposed as an expert witness (medical, not legal), and was asked how I was qualified to comment on the SOC in New Mexico. However, there is room for more discussion.

First, one might add that medical references are almost exclusively national, and sometimes even international. When seeking peer reviewed literature to support evidence based medicine, practitioners will almost always cite national journals and organizations. The source of guidelines for cardiac care will be an organization such as the American Heart Association, not the Biloxi Heart Society.

On the other hand, there are jurisdictions that still follow the "locality rule" or the doctrine of a local standard of care. In such jurisdictions, experts should be aware of the nature of the statutes and case law, since the "national education" argument applies to physicians as well as PAs, but does not necessarily trump the law in a given jurisdiction. The "locality rule" is discussed in the following article, and it's worthwhile reading at least that section.

http://jaapl.org/content/45/3/358

Then there are realistic considerations regarding specific local resources. The SOC for practitioners in a level 1 trauma center or a burn center will be different from that in a critical access hospital or an 80-bed community hospital in a remote area. The SOC in remote Alaskan villages likely differs drastically from that of an urgent care clinic in Manhattan.

Experts should be prepared to take those multiple factors and perspectives into account when testifying or, potentially, when writing reports.

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