2018 Summary of Actions

AAPA House of Delegates
New Orleans, LA
May 19-21, 2018

Note: Resolutions marked with * require AAPA Board of Directors ratification.

Resolution	Title	Line Number	Action Taken
2018-A-01*	Article III - Reference to Ethical Guidelines in Membership Bylaws	1	Adopted
2018-A-02*	Article III - Consistency in Member Benefits	19	Adopted
2018-A-03*	Article III - Student Delegate Voting	79	Adopted on Consent Agenda
2018-A-04*	Article V - Recognizing the Student Academy's Position within AAPA	93	Adopted on Consent Agenda
2018-A-05*	Article VII - Clarification of Procedures Regarding Removal of Officers	156	Adopted on Consent Agenda
2018-A-06*	Article XIII - Completion of Service Terms	175	Adopted as Amended
2018-A-07*	Article XIII - BOD Candidate Eligibility and Qualifications	199	Adopted as Amended
2018-A-08*	Article IX - Reference to Ethical Guidelines in Judicial Affairs Bylaws	234	Adopted on Consent Agenda
2018-A-09*	Article XIV - Transfer of Judicial Affairs Responsibilities to Governance Commission	273	Adopted on Consent Agenda
2018-A-10*	Article III - Recognition of Non-binary Gender Identities	293	Adopted on Consent Agenda
2018-A-11*	Articles VI, VIII, and XIII - Recognition of Non-binary Gender Identities	313	Adopted on Consent Agenda
2018-A-12	Guidelines for Ethical Conduct for the PA Profession: Recognition of Non-binary Gender Identities	376	Adopted
2018-A-13	Guidelines for Ethical Conduct	796	Adopted as Amended
2018-A-14	Genetic Testing	1408	Adopted on Consent Agenda
2018-A-15	End-of-Life Decision Making: Recognition of Non-binary Gender Identities	1414	Adopted on Consent Agenda
2018-A-16	PA Student Supervised Clinical Practice Experiences –	1583	Adopted on Consent Agenda

	Recommendations to Address Barriers: Recognition of Non-binary Gender Identities		
2018-A-17	Accreditation and Implications of Clinical Postgraduate PA Training Programs: Recognition of Non-binary Gender Identities	1608	Adopted on Consent Agenda
2018-A-18	Immunizations in Children and Adults: Recognition of Non-binary Gender Identities	1653	Adopted on Consent Agenda
2018-A-19	Guidelines for Updating Medical Staff Bylaws: Recognition of Non-binary Gender Identities	1671	Adopted on Consent Agenda
2018-A-20	HP-3500.4.1: Recognition of Non-binary Gender Identities	1764	Adopted on Consent Agenda
2018-A-21	HP-3700.1.3.2: Recognition of Non-binary Gender Identities	1773	Adopted on Consent Agenda
2018-A-22	Guidelines for the PA Serving as an Expert Witness: Recognition of Non-binary Gender Identities	1781	Adopted as Amended
2018-A-23	Licensure Eligibility for PAs Trained Abroad: Recognition of Non-binary Gender Identities	1909	Adopted on Consent Agenda
2018-B-01	PAs Contribution to Healthcare	2015	Adopted as Amended
2018-B-02	APP and APC Definition	2023	Adopted as Amended
2018-B-03	Utilization of PA or Physician Assistant	2035	Adopted
2018-B-04	Reimbursement for Medical Services	2044	Adopted
2018-B-05	Expanded Healthcare Access	2052	Adopted as Amended
2018-B-06	Federally Employed PAs	2063	Referred
2018-B-07	Recognition of PA Productivity	2106	Adopted on Consent Agenda
2018-B-08	Electronic Health Records	2116	Adopted on Consent Agenda
2018-B-09	Mental Health and Substance Use Disorder	2133	Adopted
2018-B-10	Use of Medical Interpreters for Patients with Limited English Proficiency	2150	Adopted on Consent Agenda
2018-B-11	Professional Burnout	2276	Adopted as Amended
2018-B-12	PA-Physician Ratio Restrictions	2284	Adopted on Consent Agenda
2018-B-13	Adverse Outcomes	2291	Adopted
2018-B-14	Changing the Professional Title of	2423	Adopted as

	Physician Assistants		Amended
2018-B-15	Guidelines for State Regulation of PAs	2432	Rejected
2018-B-16	Opiate Use Disorder	2700	Adopted as Amended
2018-B-17	Support for Supervised Injection Facilities	2711	Adopted on Consent Agenda
2018-B-18	Standards Requiring In-Person Instruction	2721	Referred
2018-C-01	Recognizing New PA Certifying Agencies (Tabled 2017-C-11)	2727	Adopted as Amended
2018-C-02	ACCME Support	2735	Adopted on Consent Agenda
2018-C-03	Promoting the Delivery of Healthcare Services	2745	Adopted as Amended
2018-C-04	Postgraduate Training Program Funding	2878	Adopted as Amended
2018-C-05	Obesity	2904	Adopted on Consent Agenda
2018-C-06	Organ and Tissue Donation (HP Policies)	2957	Adopted
2018-C-07	Organ and Tissue Donation (HX Policies)	2982	Adopted on Consent Agenda
2018-C-08	Human Rights – General	2997	Adopted as Amended
2018-C-09	Consumer-ordered Testing	3010	Adopted as Amended
2018-C-10	World Medical Association Declaration of Tokyo	3017	Adopted on Consent Agenda
2018-C-11	Use of Patient Drug Monitoring Programs	3026	Adopted on Consent Agenda
2018-C-12	Hospice and Palliative Medicine	3034	Adopted on Consent Agenda
2018-C-13	Increasing PA Diversity	3051	Adopted as Amended
2018-C-14	Support for PA Student Federal Loan Limits	3058	Adopted
2018-C-15	Removal of Restrictions on the Study of Gun Violence by the CDC	3063	Adopted on Consent Agenda
2018-C-16	Medications Containing Opioids and Children	3068	Referred
2018-C-17	Diversity and Non-violent Conflict Resolution	3133	Adopted on Consent Agenda
2018-C-18	Support for Decreasing Suicide	3143	Adopted

Reaffirmed Policies		
HA-2100.1.2	HP-3700.4.3	HX-4500.4
HP-3100.1.2	HP-3900.1.3	HX-4500.7

HP-3300.1.16	HX-4100.1.7	HX-4600.1.11
HP-3300.4.1	HX-4300.2.1	
HP-3700.1.3.2	HX-4300.2.5	
Expired Policies		
BA-2500.4.2	HX-4500.8	
Resolutions of Condolence	**Line Number**	**Purpose**
2018-COND-01	3164	Condolence for John Sallstrom
House Elections	**Line Number**	
Results	3206	

Bolded text within a resolution indicates the amendments submitted and accepted during the reports of the reference committees on May 21, 2018.

Presiding Officers

David I. Jackson, DHSc, PA-C, DFAAPA	Speaker
William T. Reynolds, Jr., MPAS, PA-C, DFAAPA	First Vice Speaker
Todd A. Pickard, MMSc, PA-C, DFAAPA	Second Vice Speaker

2018-A-01 – Adopted (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article III, Section 1 as follows:

ARTICLE III Membership.

Section 1: Eligibility. Membership in this Academy shall be open to all individuals wishing to participate in promoting the purposes of the Academy. Specifically, membership shall consist of individuals who are cognizant of their obligation to the public and who meet the requirements for membership as defined by AAPA's Articles of Incorporation, these Bylaws, and such other of AAPA's rules and policies that may be established from time to time. Membership in the Academy is an honor that confers upon the individual certain rights and responsibilities. Adherence to ~~the AAPA Guidelines for Ethical Conduct for the PA Profession (Policy Paper 15 – page 179),~~ AAPA's Articles of Incorporation, these Bylaws, and AAPA's rules and policies, and generally acting in a manner that is consistent with AAPA's ~~purposes~~ MISSION, is a condition of membership.

2018-A-02 – Adopted (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article III, Sections 3-10 as follows:

ARTICLE III Membership.

Section 3: Fellow Members. A fellow member shall be a PA who is a graduate of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation [CAHEA], Commission on Accreditation of Allied Health Education Programs [CAAHEP]) or who has passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) or an examination administered by another agency approved by the Academy. Fellow members must satisfy such continuing medical and/or medically related educational requirements as may be prescribed by the Academy. Non-clinical fellow members will not be required to maintain continuing medical education (CME). Fellow members shall ~~have the privileges of voting and be eligible~~ BE ENTITLED to VOTE AND hold office.

Section 4: Student Members. A student member is an individual who is enrolled in an ARC-PA or successor agency approved PA program. Except as otherwise provided in these Bylaws with respect to the election of the Student Director, student members shall not ~~have the privilege~~ BE ENTITLED to vote or hold office. Notwithstanding the preceding sentence, one student shall be elected by his/her peers to sit on the Board of Directors and this Student Director shall have ~~and enjoy~~ all rights and privileges of any other member of such Board.

Section 5: Affiliate Members. Affiliate members shall consist of individuals approved by the Membership Division of the National Office from the health professions

who desire to associate with the Academy. Affiliate members ~~shall be entitled to the privileges of the floor, but~~ shall not be entitled to vote or to hold office.

Section 6: Sustaining Members. Sustaining members shall consist of ARC-PA, CAHEA, CAAHEP or successor agency approved PA program graduates who have chosen not to actively practice in the profession and opt to be classified as sustaining members. Sustaining members ~~shall be entitled to privileges of the floor, but~~ shall not be entitled to vote or hold office.

Section 7: Physician Members. Physician members shall consist of licensed physicians who desire to associate with the Academy. Physician members ~~shall be entitled to the privileges of the floor, but~~ shall not be entitled to vote or hold office.

Section 8: Associate Members. Associate members shall consist of representatives of businesses engaged in selling products or services to PAs or individuals employed by government agencies who do not qualify for any other membership category. Associate members ~~are~~ SHALL not BE entitled ~~to the privileges of the floor,~~ to vote~~,~~ or ~~to~~ hold office.

Section 9: Honorary Members. Honorary membership may be conferred by the Academy upon non-PAs who have rendered distinguished service to the PA profession. Honorary members ~~shall have all the rights and privileges of the Academy are~~ SHALL not BE entitled to VOTE OR HOLD OFFICE. ~~of voting, holding office, and/or chairing commissions or work groups.~~ All honorary members shall be exempt from the payment of dues.

Section 10: Retired Members. A retired member shall be a PA who is a former fellow member who has chosen to retire from the profession, and opts to be classified as a retired member. Retired members ~~shall be entitled to privileges of the floor, but~~ shall not be entitled to vote or hold office.

2018-A-03 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article III, Section 4 as follows:

ARTICLE III Membership.

Section 4: Student Members. A student member is an individual who is enrolled in an ARC-PA or successor agency approved PA program. Except as otherwise provided in these Bylaws ~~with respect to the election of the Student Director~~, student members shall not have the privilege to vote or hold office. Notwithstanding the preceding sentence, one student shall be elected by his/her peers to sit on the Board of Directors and this Student Director shall have and enjoy all rights and privileges of any other member of such Board.

2018-A-04 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article V as follows:

ARTICLE V Student Academy OF AAPA.

Section 1: Purpose. The Student Academy of AAPA is the national representative body of ~~the~~ AAPA student members. ~~and, as such, while embracing all AAPA policies and purposes, the Student Academy further strives to serve students.~~ THE STUDENT ACADEMY EMBRACES THE AAPA MISSION WITH A FOCUS ON STUDENT-ORIENTED ENGAGEMENT, PROFESSIONAL DEVELOPMENT AND ADVOCACY.

SECTION 2: MEMBERSHIP. THE STUDENT ACADEMY CONSISTS OF STUDENT MEMBERS OF AAPA AS DEFINED IN AAPA BYLAWS ARTICLE III, SECTION 4.

SECTION 3: STUDENT ACADEMY RELATIONSHIP WITHIN AAPA. AAPA GRANTS THE STUDENT ACADEMY THE RIGHT TO OPERATE AS A SUBSIDIARY UNIT REPRESENTING AAPA STUDENT MEMBERS.

a. AAPA RESERVES THE RIGHT TO MONITOR THE STUDENT ACADEMY'S ADHERENCE TO AAPA'S BYLAWS AND POLICIES.
b. THE STUDENT ACADEMY RETAINS THE RIGHT TO ADDRESS STUDENT CONCERNS AND ISSUES, PROVIDED THAT THE STUDENT ACADEMY ADHERES TO THE BYLAWS, POLICIES AND PROCEDURES OF AAPA.
c. IN ORDER TO FULFILL ITS FIDUCIARY RESPONSIBILITY, THE AAPA BOARD OF DIRECTORS WILL BE APPRISED OF STUDENT ACADEMY ACTIVITIES TO ENSURE THE STUDENT ACADEMY'S COMPLIANCE WITH AAPA BYLAWS, POLICIES AND PROCEDURES, PER ARTICLE VII. SECTION 1.

SECTION 4: STUDENT ACADEMY BOARD OF DIRECTORS. THE STUDENT ACADEMY BOARD OF DIRECTORS DIRECTS THE ACTIVITIES OF THE STUDENT ACADEMY.

a. THE STUDENT ACADEMY PRESIDENT SERVES ON THE AAPA BOARD OF DIRECTORS AS THE STUDENT DIRECTOR. THE STUDENT DIRECTOR OF THE ACADEMY SHALL BE ELECTED IN THE MANNER SET FORTH IN THE STUDENT ACADEMY POLICIES, AND IN ACCORDANCE WITH THE REQUIREMENTS OF NORTH CAROLINA LAW.
b. THE STUDENT ACADEMY BOARD OF DIRECTORS IS COMPOSED OF THE PRESIDENT, PRESIDENT-ELECT, HOD CHIEF DELEGATE, REGIONAL AND FUNCTIONAL DIRECTORS, AND ADVISORS, AS SET FORTH IN AAPA AND STUDENT ACADEMY POLICIES.
c. ELECTION PROCEDURES ARE DEFINED IN THE STUDENT ACADEMY POLICIES, IN ACCORDANCE WITH THESE BYLAWS AND AAPA POLICIES AND PROCEDURES.
d. THE DUTIES OF STUDENT ACADEMY BOARD MEMBERS ARE DEFINED IN THE STUDENT ACADEMY POLICIES, IN ACCORDANCE WITH THESE BYLAWS AND AAPA POLICIES AND PROCEDURES.

Section ~~52~~: Assembly of Representatives. The Student Academy shall have an Assembly of Representatives ("AOR")~~., which shall represent the interests of AAPA student members.~~ The AOR shall be composed of STUDENT MEMBER representatives ~~of the student members~~ as set forth in the Student Academy ~~Bylaws and~~ policies. The AOR is responsible for determining the process for election of the student delegates to the AAPA House of Delegates in accordance with Article VI, Section 2.

~~Section 3: Student Director. The Student Director of the Academy shall be elected in the manner set forth in the Student Academy Bylaws and policies, and in accordance with the requirements of North Carolina law.~~

2018-A-05 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article VII, Section 9 as follows:

ARTICLE VII Board of Directors and Officers of the Corporation.

Section 9: Resignation or Removal of Directors and Officers of the Corporation. Any Director or Academy Officer may resign at any time by giving written notice to the President or the Board of Directors. Such resignation shall take effect at the time specified in such notice, or, if no time is specified, at the time such resignation is tendered. Any Director-at-large, Student Director, or Academy Officer ~~(excluding the Vice President)~~ may be removed from office at any time, with or without cause, by the affirmative majority vote of those members entitled to elect them. Removal may only occur at a meeting called for that purpose, and the meeting notice shall state that the purpose, or one of the purposes, of the meeting is removal of the Director or Officer. Vacancies in these positions shall be filled in accordance with Article XIII, Section 10 of these Bylaws. ~~Removal of the Vice President/Speaker shall be done in accordance with Article VI, Section 3 of these Bylaws pertaining to House Officers.~~

2018-A-06 – Adopted as Amended (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article XIII, Section 2 as follows:

ARTICLE XIII Elections.

Section 2: Term of Office.

A. The term of office for the Academy Officer positions of President, President-elect, and Immediate Past President shall be one year. The term of office for the Student Director shall be one year. The term of office for Directors-at-Large and for the Academy Officer position of Secretary-Treasurer shall be two years. The term of ~~service~~ OFFICE for House Officer positions shall be one year.
B. ~~OFFICERS AND DIRECTORS SEEKING ELECTION TO AN ALTERNATE OFFICE MAY ONLY DO SO IN THE LAST YEAR OF THE TERM THEY ARE CURENTLY SERVING. THEY ARE~~

~~REQUIRED TO FULFILL THE CURRENT TERM OF OFFICE BEFORE ASSUMING A NEW POSITION.~~ **OFFICERS' AND DIRECTORS' POSITIONS WILL AUTOMATICALLY BE RESIGNED EFFECTIVE AT THE END OF THE LEADERSHIP YEAR IF THE INDIVIDUAL RUNS FOR AN ALTERNATE OFFICE.**

2018-A-07 – Adopted as Amended (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article XIII, Section 3 as follows:

Section 3: Eligibility and Qualifications of Candidates for Elected Positions Other Than Student Director or Nominating Work Group Member.

a. A candidate must be a fellow member of AAPA.
b. A candidate must be a member of an AAPA Chapter.
c. A candidate must have been an AAPA fellow member and/or student member for the last three years.
d. A candidate must have accumulated at least three distinct years of experience in the past five years in at least two of the following major areas of professional involvement. This experience requirement will be waived for currently sitting AAPA Board members who choose to run for a subsequent term of office.
    i. An AAPA or constituent organization officer~~,~~ OR board member~~,~~.
    ii. AN AAPA committee, ~~council,~~ commission, work group, task force MEMBER OR chair.
    iii. A delegate to the AAPA House of Delegates or a representative to the Student Academy of the AAPA's Assembly of Representatives.
    iv. A board member, ~~OR~~ trustee~~, or committee chair~~ **OR COMMISSIONER** of the Student Academy of the AAPA, PA Foundation, Physician Assistant History Society, AAPA Political Action Committee, Physician Assistant Education Association**,** ~~or~~ National Commission on Certification of Physician Assistants~~.~~**, OR ACCREDITATION REVIEW COMMISSION ON EDUCATION FOR THE PHYSICIAN ASSISTANT.**
    v. POSITION APPOINTED BY THE AAPA PRESIDENT**, SPEAKER OF THE HOUSE** ~~**AND/**~~OR **THE** Board ~~appointee~~.

2018-A-08 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article IX as follows:

Article IX Judicial Affairs

Section 1: The Board of Directors shall be responsible for the internal judicial affairs of the Academy.

Section 2: The Academy has the inherent right through the Board of Directors to discipline, suspend, or expel an Academy member or Academy-recognized PA organization.

Section 3: Anyone may in good faith refer charges against any Academy member or ~~Academy-recognized PA organization~~ CONSTITUENT ORGANIZATION believed to have violated the Academy Articles, Bylaws, policies, or rules, or for unethical or unprofessional conduct, ~~or for failure to uphold the principles outlined in the Guidelines for Ethical Conduct for the PA Profession (Policy Paper 15 – page 179),~~ or for acting in a manner inconsistent with AAPA's ~~purposes~~ MISSION.

Section 4: The Academy, after due notice and hearing, may discipline any member or ~~Academy-recognized PA organization~~ CONSTITUENT ORGANIZATION for a violation of the Academy Articles, Bylaws, policies, or rules, or for unethical or unprofessional conduct, ~~or for failure to uphold the principles outlined in the Guidelines for Ethical Conduct for the PA Profession (Policy Paper 15 – page 179),~~ or for acting in a manner inconsistent with AAPA's ~~purposes~~ MISSION. The notice and hearing procedures for such disciplinary actions may be determined by the Board of Directors from time to time.

Section 5: If any member has their PA license or temporary permit currently revoked as the result of a final adjudicated disciplinary action for violation of their professional practice statutes or regulations, then their AAPA membership shall be automatically revoked.

Section 6: Any individual who has their PA license or temporary permit currently revoked as the result of a final adjudicated disciplinary action for violation of their professional practice statutes or regulations shall be ineligible to apply for AAPA membership during the period of that revocation.

2018-A-09 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article XIV, Section 5 and 6 as follows:

Section 5: Each amendment to be presented at the annual meeting of the House of Delegates shall be filed with the ~~Judicial Affairs~~ GOVERNANCE Commission at least three (3) months prior to that meeting. The ~~Judicial Affairs~~ GOVERNANCE Commission's proposed amendments shall be exempt from the three (3) month filing requirement.

a. To be considered for electronic vote of the House of Delegates, amendments must be submitted 150 days or greater before the annual meeting of the House of Delegates.

Section 6: Proposals that are not initiated by the Board of Directors will be presented to the Board of Directors substantially in the form presented to the ~~Judicial Affairs~~ GOVERNANCE Commission with such technical changes and conforming amendments to the proposal or existing Bylaws as the ~~Judicial Affairs~~ GOVERNANCE Commission shall deem necessary or desirable.

2018-A-10 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article III as follows:

ARTICLE III Membership.

Section 4: Student Members. A student member is an individual who is enrolled in an ARC-PA or successor agency approved PA program. Except as otherwise provided in these Bylaws with respect to the election of the Student Director, student members shall not have the privilege to vote or hold office. Notwithstanding the preceding sentence, one student shall be elected by ~~his/her peers~~ ELIGIBLE STUDENT MEMBERS to sit on the Board of Directors and this Student Director shall have and enjoy all rights and privileges of any other member of such Board.

Section 12: Suspension or Revocation of Membership. Membership in the Academy may be suspended or revoked as provided in Article IX. Any member who has been suspended or has their membership revoked shall not be entitled to any of the rights or benefits of this Academy or be permitted to take part in any of the proceedings until ~~(s)he~~ THEIR MEMBERSHIP has been reinstated.

2018-A-11 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Articles VI, VIII, and XIII as follows:

ARTICLE VI House of Delegates.

Section 3: House Officers. The House of Delegates shall elect from among its members the following House Officers: a Speaker (who shall also serve as Vice President of the Academy), a First Vice Speaker, and a Second Vice Speaker (the First Vice Speaker and the Second Vice Speaker are not Officers of the Corporation).

a. Election and Term of Service. Each House Officer shall be elected by a majority of votes cast. No absentee or proxy vote shall be cast. The Governance Commission shall determine the general procedures for House Officers elections. The terms of office shall be as specified in Article XIII, Section 2.
b. Delegate-at-large Designation. Each House Officer elected shall become a delegate- at-large during the term(s) as a House Officer, plus one additional year as an immediate past House Officer. The delegates-at-large shall be accorded all the rights and privileges of elected delegates.
c. Duties of House Officers.
    i. The Speaker shall preside at all meetings of the House of Delegates.

ii. The First Vice Speaker shall assume the duties of the Speaker in the event of the absence of the Speaker, or in the event of vacancy in the position of Speaker.

iii. The Second Vice Speaker will assume the duties of the First Vice Speaker in the absence of the First Vice Speaker, or in the event of vacancy in the position of First Vice Speaker.

iv. The Second Vice Speaker shall be responsible for verification of the credentials of the delegates, for compiling the records of all general meetings of the House of Delegates, and for submitting such records to the Secretary-Treasurer of the Academy for filing with the Academy's books and records.

d. Resignation or Removal of House Officers. Any House Officer may resign at any time by giving written notice to the Speaker, the President of the Academy, or the Board of Directors. Such resignation shall take effect at the time specified in such notice, or, if no time is specified, at the time such resignation is tendered. Any House Officer may be removed from ~~his or her position~~ OFFICE at any time, with or without cause, by the affirmative majority vote of the House of Delegates. Removal may only occur at a meeting called for that purpose, and the meeting notice shall state that the purpose, or one of the purposes, of the meeting is removal of the House Officer. Vacancies in these positions shall be filled in accordance with Article VI, Section 3 and Article XIII, Section 10 of these Bylaws.

ARTICLE VIII Chief Executive Officer.

The Chief Executive Officer (CEO) is an employee of the Academy. The CEO shall be bonded at the expense of the Academy in such amounts as the Board of Directors may require. The CEO shall be a non-voting member of the Board of Directors. The CEO shall be under the direction and oversight of the Board of Directors and, in the case of ~~his/her~~ THE CEO'S death, resignation, or removal; the Board of Directors shall have the power to fill the vacancy.

ARTICLE XIII Elections.

Section 10: Vacancies. Academy Officers and Directors, the Student Director and House Officers may resign or be removed as provided in these Bylaws. The method of filling positions vacated by the holder prior to completion of term shall be as follows:

a. OFFICE OF THE PRESIDENT. The President-elect shall become the President to serve the unexpired term. The President-elect shall then serve ~~his/her own~~ A successive term as President.

2018-A-12 – Adopted

Amend policy HP-3700.1.2 entitled "Guidelines Ethical Conduct for the PA Profession" as follows:

Guidelines for Ethical Conduct for the PA Profession

(Adopted 2000, amended 2004, 2006, 2007, 2008, reaffirmed 2013)

Introduction
Statement of Values of the PA Profession
The PA and Patient
PA Role and Responsibilities
The PA and Diversity
Nondiscrimination
Initiation and Discontinuation of Care
Informed Consent
Confidentiality
The Patient and the Medical Record
Disclosure
Care of Family Members and Co-workers
Genetic Testing
Reproductive Decision Making
End of Life
The PA and Individual Professionalism
Conflict of Interest
Professional Identity
Competency
Sexual Relationships
Gender Discrimination and Sexual Harassment
The PA and Other Professionals
Team Practice
Illegal and Unethical Conduct
Impairment
PA-Physician Relationship
Complementary and Alternative Medicine
The PA and the Health Care System
Workplace Actions
PAs as Educators
PAs and Research
PAs as Expert Witnesses
The PA and Society
Lawfulness
Executions
Access to Care / Resource Allocation
Community Well Being
Conclusion

Introduction

The PA profession has revised its code of ethics several times since the profession began. Although the fundamental principles underlying the ethical care of patients have not changed, the societal framework in which those principles are applied has. Economic pressures of the health care system, social pressures of church and state, technological advances, and changing patient demographics continually transform the landscape in which PAs practice.

Previous codes of the profession were brief lists of tenets for PAs to live by in their professional lives. This document departs from that format by attempting to describe ways in which those tenets apply. Each situation is unique. Individual PAs must use their best judgment in a given situation while considering the preferences of the patient and the supervising physician, clinical information, ethical concepts, and legal obligations.

Four main bioethical principles broadly guided the development of these guidelines: autonomy, beneficence, nonmaleficence, and justice.

Autonomy, strictly speaking, means self-rule. Patients have the right to make autonomous decisions and choices, and PAs should respect these decisions and choices. Beneficence means that PAs should act in the patient's best interest. In certain cases, respecting the patient's autonomy and acting in their best interests may be difficult to balance.

Nonmaleficence means to do no harm, to impose no unnecessary or unacceptable burden upon the patient.

Justice means that patients in similar circumstances should receive similar care. Justice also applies to norms for the fair distribution of resources, risks, and costs.

PAs are expected to behave both legally and morally. They should know and understand the laws governing their practice. Likewise, they should understand the ethical responsibilities of being a health care professional. Legal requirements and ethical expectations will not always be in agreement. Generally speaking, the law describes minimum standards of acceptable behavior, and ethical principles delineate the highest moral standards of behavior.

When faced with an ethical dilemma, PAs may find the guidance they need in this document. If not, they may wish to seek guidance elsewhere □ possibly from a supervising physician, a hospital ethics committee, an ethicist, trusted colleagues, or other AAPA policies. PAs should seek legal counsel when they are concerned about the potential legal consequences of their decisions.

The following sections discuss ethical conduct of PAs in their professional interactions with patients, physicians, colleagues, other health professionals, and the public. The "Statement of Values" within this document defines the fundamental values that the PA profession strives to uphold. These values provide the foundation upon which the guidelines rest. The guidelines were written with the understanding that no document can encompass all actual and potential ethical responsibilities, and PAs should not regard them as comprehensive.

Statement of Values of the PA Profession

- PAs hold as their primary responsibility the health, safety, welfare, and dignity of all human beings.
- PAs uphold the tenets of patient autonomy, beneficence, nonmaleficence, and justice.
- PAs recognize and promote the value of diversity.
- PAs treat equally all persons who seek their care.
- PAs hold in confidence the information shared in the course of practicing medicine.
- PAs assess their personal capabilities and limitations, striving always to improve their medical practice.
- PAs actively seek to expand their knowledge and skills, keeping abreast of advances in medicine.

- PAs work with other members of the health care team to provide compassionate and effective care of patients.
- PAs use their knowledge and experience to contribute to an improved community.
- PAs respect their professional relationship with physicians.
- PAs share and expand knowledge within the profession.

The PA and Patient

PA Role and Responsibilities

PA practice flows out of a unique relationship that involves the PA, the physician, and the patient. The individual patient–PA relationship is based on mutual respect and an agreement to work together regarding medical care. In addition, PAs practice medicine with physician supervision; therefore, the care that a PA provides is an extension of the care of the supervising physician. The patient–PA relationship is also a patient–PA–physician relationship.

The principal value of the PA profession is to respect the health, safety, welfare, and dignity of all human beings. This concept is the foundation of the patient–PA relationship. PAs have an ethical obligation to see that each of their patients receives appropriate care. PAs should be sensitive to the beliefs and expectations of the patient. PAs should recognize that each patient is unique and has an ethical right to self-determination

PAs are professionally and ethically committed to providing nondiscriminatory care to all patients. While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. A PA has an ethical duty to offer each patient the full range of information on relevant options for their health care. If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer a patient to another qualified provider. That referral should not restrict a patient's access to care. PAs are obligated to care for patients in emergency situations and to responsibly transfer patients if they cannot care for them.

PAs should always act in the best interests of their patients and as advocates when necessary. PAs should actively resist policies that restrict free exchange of medical information. For example, a PA should not withhold information about treatment options simply because the option is not covered by insurance. PAs should inform patients of financial incentives to limit care, use resources in a fair and efficient way, and avoid arrangements or financial incentives that conflict with the patient's best interests.

The PA and Diversity

The PA should respect the culture, values, beliefs, and expectations of the patient.

Nondiscrimination

PAs should not discriminate against classes or categories of patients in the delivery of needed health care. Such classes and categories include gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, physical stature, body size, gender identity, marital status, or sexual orientation.

Initiation and Discontinuation of Care

In the absence of a preexisting patient–PA relationship, the PA is under no ethical obligation to care for a person unless no other provider is available. A PA is morally bound to provide care in emergency situations and to arrange proper follow-up. PAs

should keep in mind that contracts with health insurance plans might define a legal obligation to provide care to certain patients.

A PA and supervising physician may discontinue their professional relationship with an established patient as long as proper procedures are followed. The PA and physician should provide the patient with adequate notice, offer to transfer records, and arrange for continuity of care if the patient has an ongoing medical condition. Discontinuation of the professional relationship should be undertaken only after a serious attempt has been made to clarify and understand the expectations and concerns of all involved parties.

If the patient decides to terminate the relationship, they are entitled to access appropriate information contained within their medical record.

Informed Consent

PAs have a duty to protect and foster an individual patient's free and informed choices. The doctrine of informed consent means that a PA provides adequate information that is comprehendible to a competent patient or patient surrogate. At a minimum, this should include the nature of the medical condition, the objectives of the proposed treatment, treatment options, possible outcomes, and the risks involved. PAs should be committed to the concept of shared decision making, which involves assisting patients in making decisions that account for medical, situational, and personal factors.

In caring for adolescents, the PA should understand all of the laws and regulations in ~~his or her~~ THE PA'S jurisdiction that are related to the ability of minors to consent to or refuse health care. Adolescents should be encouraged to involve their families in health care decision making. The PA should also understand consent laws pertaining to emancipated or mature minors. (See the section on ***Confidentiality***.)

When the person giving consent is a patient's surrogate, a family member, or other legally authorized representative, the PA should take reasonable care to assure that the decisions made are consistent with the patient's best interests and personal preferences, if known. If the PA believes the surrogate's choices do not reflect the patient's wishes or best interests, the PA should work to resolve the conflict. This may require the use of additional resources, such as an ethics committee.

Confidentiality

PAs should maintain confidentiality. By maintaining confidentiality, PAs respect patient privacy and help to prevent discrimination based on medical conditions. If patients are confident that their privacy is protected, they are more likely to seek medical care and more likely to discuss their problems candidly.

In cases of adolescent patients, family support is important but should be balanced with the patient's need for confidentiality and the PA's obligation to respect their emerging autonomy. Adolescents may not be
of age to make independent decisions about their health, but providers should respect that they soon will be. To the extent they can, PAs should allow these emerging adults to participate as fully as possible in decisions about their care. It is important that PAs be familiar with and understand the laws and regulations in their jurisdictions that relate to the confidentiality rights of adolescent patients. (See the section on *Informed Consent*.)

Any communication about a patient conducted in a manner that violates confidentiality is unethical. Because written, electronic, and verbal information may be intercepted or overheard, the PA should always be aware of anyone who might be monitoring communication about a patient.

PAs should choose methods of storage and transmission of patient information that minimize the likelihood of data becoming available to unauthorized persons or organizations. Computerized record keeping and electronic data transmission present unique challenges that can make the maintenance of patient confidentiality difficult. PAs should advocate for policies and procedures that secure the confidentiality of patient information.

The Patient and the Medical Record

PAs have an obligation to keep information in the patient's medical record confidential. Information should be released only with the written permission of the patient or the patient's legally authorized representative. Specific exceptions to this general rule may exist (e.g., workers compensation, communicable disease, HIV, knife/gunshot wounds, abuse, substance abuse). It is important that a PA be familiar with and understand the laws and regulations in ~~his or her~~ THE PA'S jurisdiction that relate to the release of information. For example, stringent legal restrictions on release of genetic test results and mental health records often exist.

Both ethically and legally, a patient has certain rights to know the information contained in ~~his or her~~ THE PATIENT'S medical record. While the chart is legally the property of the practice or the institution, the information in the chart is the property of the patient. Most states have laws that provide patients access to their medical records. The PA should know the laws and facilitate patient access to the information.

Disclosure

A PA should disclose ~~to his or her supervising physician~~ information about errors made in the course of caring for a patient TO THE PA'S SUPERVISING PHYSICIAN. The supervising physician and PA should disclose the error to the patient if such information is significant to the patient's interests and well being. Errors do not always constitute improper, negligent, or unethical behavior, but failure to disclose them may.

Care of Family Members and Co-workers

Treating oneself, co-workers, close friends, family members, or students whom the PA supervises or teaches may be unethical or create conflicts of interest. For example, it might be ethically acceptable to treat one's own child for a case of otitis media but it probably is not acceptable to treat one's spouse for depression. PAs should be aware that their judgment might be less than objective in cases involving friends, family members, students, and colleagues and that providing "curbside" care might sway the individual from establishing an ongoing relationship with a provider. If it becomes necessary to treat a family member or close associate, a formal patient-provider relationship should be established, and the PA should consider transferring the patient's care to another provider as soon as it is practical. If a close associate requests care, the PA may wish to assist by helping them find an appropriate provider.

There may be exceptions to this guideline, for example, when a PA runs an employee health center or works in occupational medicine. Even in those situations, the PA should be sure they do not provide informal treatment, but provide appropriate medical care in a formally established patient-provider relationship.

Genetic Testing

Evaluating the risk of disease and performing diagnostic genetic tests raise significant ethical concerns. PAs should be informed about the benefits and risks of genetic tests. Testing should be undertaken only after proper informed consent is obtained. If PAs order or conduct the tests, they should assure that appropriate pre- and post-test counseling is provided.

PAs should be sure that patients understands the potential consequences of undergoing genetic tests from impact on patients themselves, possible implications for other family members, and potential use of the information by insurance companies or others who might have access to the information. Because of the potential for discrimination by insurers, employers, or others, PAs should be particularly aware of the need for confidentiality concerning genetic test results.

Reproductive Decision Making

Patients have a right to access the full range of reproductive health care services, including fertility treatments, contraception, sterilization, and abortion. PAs have an ethical obligation to provide balanced and unbiased clinical information about reproductive health care.

When the PA's personal values conflict with providing full disclosure or providing certain services such as sterilization or abortion, the PA need not become involved in that aspect of the patient's care. By referring the patient to a qualified provider who is willing to discuss and facilitate all treatment options, the PA fulfills their ethical obligation to ensure the patient's access to all legal options.

End of Life

Among the ethical principles that are fundamental to providing compassionate care at the end of life, the most essential is recognizing that dying is a personal experience and part of the life cycle.

PAs should provide patients with the opportunity to plan for end of life care. Advance directives, living wills, durable power of attorney, and organ donation should be discussed during routine patient visits.

PAs should assure terminally-ill patients that their dignity is a priority and that relief of physical and mental suffering is paramount. PAs should exhibit non-judgmental attitudes and should assure their terminally-ill patients that they will not be abandoned. To the extent possible, patient or surrogate preferences should be honored, using the most appropriate measures consistent with their choices, including alternative and non-traditional treatments. PAs should explain palliative and hospice care and facilitate patient access to those services. End of life care should include assessment and management of psychological, social, and spiritual or religious needs.

While respecting patients' wishes for particular treatments when possible, PAs also must weigh their ethical responsibility, in consultation with supervising physicians, to withhold futile treatments and to help patients understand such medical decisions.

PAs should involve the physician in all near-death planning. The PA should only withdraw life support with the supervising physician's agreement and in accordance with the policies of the health care institution.

The PA and Individual Professionalism

Conflict of Interest

PAs should place service to patients before personal material gain and should avoid undue influence on their clinical judgment. Trust can be undermined by even the appearance of improper influence. Examples of excessive or undue influence on clinical judgment can take several forms. These may include financial incentives, pharmaceutical or other industry gifts, and business arrangements involving referrals. PAs should disclose any actual or potential conflict of interest to their patients.

Acceptance of gifts, trips, hospitality, or other items is discouraged. Before accepting a gift or financial arrangement, PAs might consider the guidelines of the Royal College of Physicians, "Would I be willing to have this arrangement generally known?"

or of the American College of Physicians, “What would the public or my patients think of this arrangement?”

Professional Identity

PAs should not misrepresent directly or indirectly, their skills, training, professional credentials, or identity. PAs should uphold the dignity of the PA profession and accept its ethical values.

Competency

PAs should commit themselves to providing competent medical care and extend to each patient the full measure of their professional ability as dedicated, empathetic health care providers. PAs should also strive to maintain and increase the quality of their health care knowledge, cultural sensitivity, and cultural competence through individual study and continuing education.

Sexual Relationships

It is unethical for PAs to become sexually involved with patients. It also may be unethical for PAs to become sexually involved with former patients or key third parties. Key third parties are individuals who have influence over the patient. These might include spouses or partners, parents, guardians, or surrogates.

Such relationships generally are unethical because of the PA’s position of authority and the inherent imbalance of knowledge, expertise, and status. Issues such as dependence, trust, transference, and inequalities of power may lead to increased vulnerability on the part of the current or former patients or key third parties.

Gender Discrimination and Sexual Harassment

It is unethical for PAs to engage in or condone any form of gender discrimination. Gender discrimination is defined as any behavior, action, or policy that adversely affects an individual or group of individuals due to disparate treatment, disparate impact, or the creation of a hostile or intimidating work or learning environment.

It is unethical for PAs to engage in or condone any form of sexual harassment. Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature when:

- Such conduct has the purpose or effect of interfering with an individual's work or academic performance or creating an intimidating, hostile or offensive work or academic environment, or
- Accepting or rejecting such conduct affects or may be perceived to affect professional decisions concerning an individual, or
- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's training or professional position.

<u>The PA and Other Professionals</u>

Team Practice

PAs should be committed to working collegially with other members of the health care team to assure integrated, well-managed, and effective care of patients. PAs should strive to maintain a spirit of cooperation with other health care professionals, their organizations, and the general public.

Illegal and Unethical Conduct

PAs should not participate in or conceal any activity that will bring discredit or dishonor to the PA profession. They should report illegal or unethical conduct by health care professionals to the appropriate authorities.

Impairment

PAs have an ethical responsibility to protect patients and the public by identifying and assisting impaired colleagues. “Impaired” means being unable to practice medicine with reasonable skill and safety because of physical or mental illness, loss of motor skills, or excessive use or abuse of drugs and alcohol.

PAs should be able to recognize impairment in physician supervisors, PAs, and other health care providers and should seek assistance from appropriate resources to encourage these individuals to obtain treatment.

PA–Physician Relationship

Supervision should include ongoing communication between the physician and the PA regarding patient care. The PA should consult the supervising physician whenever it will safeguard or advance the welfare of the patient. This includes seeking assistance in situations of conflict with a patient or another health care professional.

Complementary and Alternative Medicine

When a patient asks about an alternative therapy, the PA has an ethical obligation to gain a basic understanding of the alternative therapy being considered or being used and how the treatment will affect the patient. If the treatment would harm the patient, the PA should work diligently to dissuade the patient from using it, advise other treatment, and perhaps consider transferring the patient to another provider.

The PA and the Health Care System

Workplace Actions

PAs may face difficult personal decisions to withhold medical services when workplace actions (e.g., strikes, sick-outs, slowdowns, etc.) occur. The potential harm to patients should be carefully weighed against the potential improvements to working conditions and, ultimately, patient care that could result. In general, PAs should individually and collectively work to find alternatives to such actions in addressing workplace concerns.

PAs as Educators

All PAs have a responsibility to share knowledge and information with patients, other health professionals, students, and the public. The ethical duty to teach includes effective communication with patients so that they will have the information necessary to participate in their health care and wellness.

PAs and Research

The most important ethical principle in research is honesty. This includes assuring subjects’ informed consent, following treatment protocols, and accurately reporting findings. Fraud and dishonesty in research should be reported so that the appropriate authorities can take action.

PAs involved in research must be aware of potential conflicts of interest. The patient's welfare takes precedence over the desired research outcome. Any conflict of interest should be disclosed.

In scientific writing, PAs should report information honestly and accurately. Sources of funding for the research must be included in the published reports. Plagiarism is unethical. Incorporating the words of others, either verbatim or by paraphrasing, without appropriate attribution is unethical and may have legal consequences. When submitting a document for publication, any previous publication of any portion of the document must be fully disclosed.

PAs as Expert Witnesses

The PA expert witness should testify to what he or she believes to be the truth. The PA’s review of medical facts should be thorough, fair, and impartial.

The PA expert witness should be fairly compensated for time spent preparing, appearing, and testifying. The PA should not accept a contingency fee based on the outcome of a case in which testimony is given or derive personal, financial, or professional favor in addition to compensation.

The PA and Society

Lawfulness

PAs have the dual duty to respect the law and to work for positive change to laws that will enhance the health and well-being of the community.

Executions

PAs, as health care professionals, should not participate in executions because to do so would violate the ethical principle of beneficence.

Access to Care / Resource Allocation

PAs have a responsibility to use health care resources in an appropriate and efficient manner so that all patients have access to needed health care. Resource allocation should be based on societal needs and policies, not the circumstances of an individual patient–PA encounter. PAs participating in policy decisions about resource allocation should consider medical need, cost-effectiveness, efficacy, and equitable distribution of benefits and burdens in society.

Community Well Being

PAs should work for the health, well-being, and the best interest of both the patient and the community. Sometimes there is a dynamic moral tension between the well-being of the community in general and the individual patient. Conflict between an individual patient's best interest and the common good is not always easily resolved. In general, PAs should be committed to upholding and enhancing community values, be aware of the needs of the community, and use the knowledge and experience acquired as professionals to contribute to an improved community.

Conclusion

AAPA recognizes its responsibility to aid the PA profession as it strives to provide high quality, accessible health care. PAs wrote these guidelines for themselves and other PAs. The ultimate goal is to honor patients and earn their trust while providing the best and most appropriate care possible. At the same time, PAs must understand their personal values and beliefs and recognize the ways in which those values and beliefs can impact the care they provide.

2018-A-13 – Adopted as Amended

Amend policy HP-3700.1.2 entitled "Guidelines for Ethical Conduct for the PA Profession".

Guidelines for Ethical Conduct for the PA Profession

(*Adopted 2000, amended 2004, 2006, 2007, 2008, reaffirmed 2013*)

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~~**Conclusion**~~

EXECUTIVE SUMMARY OF POLICY CONTAINED IN THIS PAPER

SUMMARIES WILL LACK RATIONALE AND BACKGROUND INFORMATION, AND MAY LOSE NUANCE OF POLICY. YOU ARE HIGHLY ENCOURAGED TO READ THE ENTIRE PAPER.

- INDIVIDUAL PAS MUST USE THEIR BEST JUDGMENT IN A GIVEN SITUATION WHILE CONSIDERING THE PREFERENCES OF THE PATIENT, THE HEALTHCARE TEAM, CLINICAL INFORMATION, ETHICAL PRINCIPLES, AND LEGAL OBLIGATIONS.
- THE FOUR MAIN BIOETHICAL PRINCIPLES WHICH BROADLY GUIDED THE DEVELOPMENT OF THESE GUIDELINES ARE PATIENT AUTONOMY, BENEFICENCE, NONMALEFICENCE, AND JUSTICE.
- THE STATEMENT OF VALUES WITHIN THIS DOCUMENT DEFINES THE FUNDAMENTAL VALUES THE PA PROFESSION STRIVES TO UPHOLD. THE PRIMARY VALUE IS THE PA'S RESPONSIBILITY TO THE HEALTH, SAFETY, WELFARE, AND DIGNITY OF ALL HUMAN BEINGS.

Introduction

The PA profession has revised its code of ethics several times since the profession began. Although the fundamental principles underlying the ethical care of patients have not changed, the societal framework in which those principles are applied ARE CONSTANTLY CHANGING ~~has~~. Economic pressures ~~of the healthcare system~~, social pressures of church and state ON THE HEALTHCARE SYSTEM, technological advances, and changing patient demographics continually transform the landscape in which PAs practice. THIS POLICY, AS WRITTEN, REFLECTS A POINT IN TIME AND SHOULD BE REVIEWED THOUGH THAT LENS. IT IS A LIVING DOCUMENT TO BE CONTINUALLY REVIEWED AND UPDATED TO REFLECT THE CHANGING TIMES, BE THEY RELATED TO SOCIETAL EVOLUTIONS OR THE ADVANCEMENT OF MEDICAL SCIENCE.

Previous codes of the profession were brief lists of tenets for PAs to live by in their professional lives. This document departs from that format by GOING A STEP FURTHER AND ~~attempting to describe ways in which those~~ DESCRIBING HOW THESE tenets apply TO PA PRACTICE. Each situation is unique. Individual PAs must use their best judgment in a given situation while considering the preferences of the patient and ~~the supervising physician~~ THE HEALTHCARE TEAM, clinical information, ethical PRINCIPLES ~~concepts~~, and legal obligations. CONTEXT AND/OR CASUISTRY (EXTRACTING REASONING FROM CASE STUDY), OFTEN PLAY KEY ROLES IN DECISION MAKING.

Four main bioethical principles broadly guided the development of these guidelines: PATIENT autonomy, beneficence, nonmaleficence, and justice. (1)

Autonomy, strictly speaking, means self-rule. Patients have the right to make autonomous decisions and choices, and PAs should respect these decisions and choices.

Beneficence means that PAs should act in the patient's best interest. In certain cases, respecting the patient's autonomy and acting in their best interests may be difficult to balance.

Nonmaleficence means to do no harm, to impose no unnecessary or unacceptable burden upon the patient.

Justice means that patients in similar circumstances should receive similar care. Justice also applies to norms for the fair distribution of resources, risks, and costs.

PAs are expected to behave both legally and morally. They should know and understand the LOCAL, STATE AND FEDERAL laws governing their practice. Likewise, they should understand the ethical responsibilities of being a healthcare professional. Legal requirements and ethical expectations will not always be in agreement. Generally speaking, the law describes minimum standards of acceptable behavior, and ethical principles delineate the highest moral standards of behavior.

When faced with an ethical dilemma, PAs may find the guidance they need in this document. If not, they may wish to seek guidance elsewhere – possibly from a ~~**SUPERVISOR supervising physician, a**~~ hospital ethics committee, an ethicist, trusted colleagues, or other AAPA policies. PAs should seek legal counsel when they are concerned about the potential legal consequences of their decisions.

The following sections discuss ethical conduct of PAs in their professional interactions with patients, physicians, colleagues, other health professionals, and the public. The "Statement of Values" within this document defines the fundamental values that the PA profession strives to uphold. These values provide the foundation upon which the guidelines rest. The guidelines were written with the understanding that no document

can encompass all actual and potential ethical responsibilities, and PAs should not regard them as comprehensive.

Statement of Values of the PA Profession

- PAs hold as their primary responsibility the health, safety, welfare, and dignity of all human beings.
- PAs uphold the tenets of patient autonomy, beneficence, nonmaleficence, and justice.(1)
- PAs recognize and promote the value of diversity.
- PAs DO NOT DISCRIMINATE; PAS treat equally all persons who seek their care.
- PAs hold in confidence the PATIENT-SPECIFIC information shared in the course of practicing medicine.
- ~~PAs assess their personal capabilities and limitations, striving always to improve their medical practice.~~
- PAs actively seek to expand their knowledge and skills, keeping abreast of advances in medicine. PAS ASSESS THEIR PERSONAL CAPABILITIES AND LIMITATIONS, STRIVING ALWAYS TO IMPROVE THEIR PRACTICE OF MEDICINE.
- PAs work with other members of the healthcare team to provide compassionate and effective care of patients.
- PAs use their knowledge and experience to contribute to A HEALTHY COMMUNITY AND THE IMPROVEMENT OF PUBLIC HEALTH. ~~an improved community.~~
- PAs respect their professional relationship with ~~physicians~~ ALL MEMBERS OF THE HEALTHCARE TEAM.
- PAs share and expand CLINICAL AND PROFESSIONAL knowledge with~~in~~ PAS AND PA STUDENTS. ~~the profession.~~

The PA and Patient

PA Role and Responsibilities

~~PA practice flows out of a unique relationship that involves the PA, the physician, and the patient. The individual patient–PA relationship is based on mutual respect and an agreement to work together regarding medical care. In addition, PAs may practice medicine with physician supervision; therefore, the care that a PA provides is an extension of the care of the supervising physician. The patient–PA relationship is also a patient–PA–physician relationship~~.

The principal value of the PA profession is to respect the health, safety, welfare, and dignity of all human beings. This concept is the foundation of the patient–PA relationship. PAs have an ethical obligation to see that each of their patients receives appropriate care. PAs should be sensitive to the beliefs and expectations of the patient. PAs should recognize that each patient is unique and has an ethical right to self-determination.

PAs are professionally and ethically committed to providing nondiscriminatory care to all patients. While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. A PA has an ethical duty to offer each patient the full range of information on relevant options for their healthcare. If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care

the patient desires, the PA has an ethical duty to refer a patient to another qualified provider. That referral should not restrict a patient's access to care. PAs are obligated to care for patients in emergency situations and to responsibly transfer patients if they cannot care for them.

PAs should always act in the best interests of their patients and as advocates when necessary. WHILE RESPECTING THE LAW, PAs should actively resist policies that restrict free exchange of medical information WHETHER THE RESTRICTIONS ARE COMING FROM THEIR INSTITUTION, REGULATORS OR LEGISLATORS. For example, ~~a PA should not withhold information about treatment options simply because the option is not covered by insurance.~~ PAs should inform patients of financial incentives to limit care, use resources in a fair and efficient way, and avoid arrangements or financial incentives that conflict with the patient's best interests.

The PA and Diversity

The PA should respect the culture, values, beliefs, and expectations of the patient.

Nondiscrimination OF PATIENTS **AND FAMILIES**

PAs should not discriminate against classes or categories of patients in the delivery of needed healthcare. Such classes and categories include gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, physical stature, body size, gender identity, marital status, or sexual orientation.

SEE ALSO SECTION ON NONDISCRIMINATION IN THE WORKPLACE AND CLASSROOM

Initiation and Discontinuation of Care

In the absence of a preexisting patient–PA relationship, the PA is under no ethical obligation to care for a person unless no other provider is available. A PA is morally bound to provide care in emergency situations and, WHEN NECESSARY, to arrange proper follow-up. PAs should keep in mind that contracts with health insurance plans might define a legal obligation to provide care to certain patients.

CARE CAN BE DISCONTINUED FOR MANY REASONS, SOME POSITIVE (SUCH AS RETIREMENT OR A NEW POSITION) AND SOME NEGATIVE (SUCH AS THREATENING BEHAVIOR BY THE PATIENT OR DEMONSTRATING NON-COMPLIANCE WITH RECOMMENDED MEDICAL CARE).

A ~~PA and supervising physician may discontinue their~~ professional relationship with an established patient MAY BE DISCONTINUED **as long as proper procedures are followed.** The ~~PA and physician~~ PATIENT should BE PROVIDED ~~provide the patient~~ with adequate notice, offer to transfer records, and arrange for continuity of care if the patient has an ongoing medical condition. IN THE EVENT THAT ~~D~~discontinuation ~~of the professional relationship~~ IS THE RESULT OF A PROBLEMATIC RELATIONSHIP, DISCONTINUATION should be undertaken only after a serious attempt has been made to clarify and understand the expectations and concerns of all involved parties.

If the patient decides to terminate the relationship, they are entitled to access appropriate information contained within their medical record.

MANY REGULATORY BOARDS HAVE RULES OR POSITION STATEMENTS ADDRESSING TERMINATION OF CARE. PAS SHOULD UNDERSTAND ANY REGULATORY REQUIREMENTS BEFORE TAKING ACTION.

Informed Consent

PAs have a duty to protect and foster an individual patient's free and informed choices. The doctrine of informed consent means that a PA provides adequate information that is comprehendible to a ~~competent~~ patient or patient surrogate **~~THAT~~ WHO** HAS MEDICAL DECISION-MAKING CAPACITY. At a minimum, this should include the nature of the medical condition, the objectives of the proposed treatment, treatment options, possible outcomes, and the risks involved. PAs **~~should be~~ ARE EXPECTED TO BE** committed to the concept of shared decision making, which involves assisting patients in making decisions that account for medical, situational and personal factors.

SEE ALSO, AAPA POLICY PAPER, USE OF MEDICAL INTERPRETERS FOR PATIENTS WITH LIMITED ENGLISH PROFICIENCY.

In caring for adolescents, the PA **~~should~~ MUST** understand all of the laws and regulations in his or her jurisdiction that are related to the ability of minors to consent to or refuse healthcare. Adolescents should be encouraged to involve their families in healthcare decision making. The PA **~~should~~ IS EXPECTED TO ~~also~~** understand consent laws pertaining to emancipated or mature minors.

~~(~~*See ALSO, the section on Confidentiality AND THE AAPA POLICY PAPER, ATTEMPTS TO CHANGE A MINOR'S SEXUAL ORIENTATION, GENDER IDENTITY, OR GENDER EXPRESSION.*~~)~~

When the person giving consent is a patient's surrogate, a family member, or other legally authorized representative, the PA should take reasonable care to assure that the decisions made are consistent with the patient's best interests and personal preferences, if known. If the PA believes the surrogate's choices do not reflect the patient's wishes or best interests, the PA should work to resolve the conflict. This may require the use of additional resources, such as an ethics committee.

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PAs should maintain confidentiality. By maintaining confidentiality, PAs respect patient privacy and help to prevent discrimination based on medical conditions. If patients are confident that their privacy is protected, they are more likely to seek medical care and more likely to discuss their problems candidly.

In cases of adolescent patients, family support is important but should be balanced with the patient's need for confidentiality and the PA's obligation to respect their emerging autonomy. Adolescents may not be of age to make independent decisions about their health, but providers should respect that they soon will be. To the extent they can, PAs should allow these emerging adults to participate as fully as possible in decisions about their care. It is important that PAs be familiar with and understand INSTITUTIONAL POLICIES AND LOCAL, STATE AND FEDERAL ~~the~~ laws and regulations, ~~in their jurisdictions~~ that relate to the confidentiality rights of adolescent patients.

~~(~~*See ALSO, the section on Informed Consent.*~~)~~

Any communication about a patient conducted in a manner that violates confidentiality is unethical. Because written, electronic, and verbal information may be intercepted or overheard, the PA should always be aware of anyone who might be monitoring communication about a patient.

PAs should USE AND ADVOCATE FOR ~~choose~~ methods of storage and transmission of patient information that minimize the likelihood of data becoming available to unauthorized persons or organizations. Computerized record keeping and electronic data transmission present unique challenges that can make the maintenance of

patient confidentiality difficult. PAs should advocate for policies and procedures that secure the confidentiality of patient information.

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PAs have an obligation to keep information in the patient's medical record confidential. Information should be released only with the written permission of the patient or the patient's legally authorized representative. Specific exceptions to this general rule may exist (e.g., workers compensation, communicable disease, HIV, knife/gunshot wounds, abuse, and substance abuse). It is important that a PA be familiar with and understand the INSTITUTIONAL POLICIES AND LOCAL, STATE AND FEDERAL laws and regulations ~~in his or her jurisdiction~~ that relate to the release of information. For example, stringent legal restrictions on release of genetic test results and mental health records often exist.

Both ethically and legally, a patient has certain rights to know the information contained in his or her medical record. While the chart is legally the property of the practice or the institution, the information in the chart is the property of the patient. Most states have laws that provide patients access to their medical records. The PA should know the laws and facilitate patient access to the information.

Disclosure OF MEDICAL ERRORS

A PATIENT DESERVES COMPLETE AND HONEST EXPLANATIONS OF MEDICAL ERRORS AND ADVERSE OUTCOMES. ~~A PA should disclose to his or her supervising physician information about errors made in the course of caring for a patient.~~ The ~~supervising physician and~~ PA should disclose the error to the patient if such information is significant to the patient's interests and well-being. Errors do not always constitute improper, negligent, or unethical behavior, but failure to disclose them may.

SEE AAPA POLICY PAPER, ACKNOWLEDGING AND APOLOGIZING FOR ADVERSE OUTCOMES.

Care of Family Members and Co-workers

Treating oneself, co-workers, close friends, family members, or students whom the PA supervises or teaches ~~may be~~ IS CONTEXTUAL (2, 3) AND CASUISTIC (EXTRACING REASON FROM CASE STUDY) ~~unethical or create conflicts of interest~~. For example, it might be ethically acceptable to treat one's own child for a case of otitis media, but it probably is not acceptable to treat one's spouse for depression. PAs should be aware that their judgment might be less than objective in cases involving friends, family members, students, and colleagues and that providing "curbside" care might sway the individual from establishing an ongoing relationship with a provider. If it becomes necessary to treat a family member or close associate, a formal patient-provider relationship should be established, and the PA should consider transferring the patient's care to another provider as soon as it is practical. If a close associate requests care, the PA may wish to assist by helping them find an appropriate provider.

There may be exceptions to this guideline, for example, when a PA runs an employee health center or works in occupational medicine. Even in those situations, the PA should be sure they do not provide informal treatment, but provide appropriate medical care in a formally established patient-provider relationship.

Genetic Testing

Evaluating the risk of disease and performing diagnostic genetic tests raise significant ethical concerns. PAs should be informed about the benefits and risks of genetic tests. Testing should be undertaken only after proper informed consent is obtained. If PAs order or conduct the tests, OR HAVE ACCESS TO THE RESULTS AS

A CONSEQUENCE OF PATIENT CARE, they should assure that appropriate pre- and post-test counseling is provided.

PAs should be sure that patients understand~~s~~ the potential consequences of undergoing genetic tests – from impact on patients themselves, possible implications for other family members, and potential use of the information by insurance companies or others who might have access to the information. Because of the potential for discrimination by insurers, employers, or others, PAs should be particularly aware of the need for confidentiality concerning genetic test results.

Reproductive Decision Making

Patients have a right to access the full range of reproductive healthcare services, including fertility treatments, contraception, sterilization, and abortion. PAs have an ethical obligation to provide balanced and unbiased clinical information about reproductive healthcare.

When the PA's personal values conflict with providing full disclosure or providing certain services such as sterilization or abortion, the PA need not become involved in that aspect of the patient's care. By referring the patient to a qualified provider who is willing to discuss and facilitate all treatment options, the PA fulfills their ethical obligation to ensure the patient's access to all legal options.

End of Life

Among the ethical principles that are fundamental to providing compassionate care at the end of life, the most essential is recognizing that dying is a personal experience and part of the life cycle.

PAs should provide patients with the opportunity to plan for end of life care. Advance directives, living wills, durable power of attorney, and organ donation should be discussed during routine patient visits.

PAs should assure terminally-ill patients that their dignity is a priority and that relief of physical and mental suffering is paramount. PAs should exhibit non-judgmental attitudes and should assure their terminally-ill patients that they will not be abandoned. To the extent possible, patient or surrogate preferences should be honored, using the most appropriate measures consistent with their choices, including alternative and non-traditional treatments. PAs should explain palliative and hospice care and facilitate patient access to those services. End of life care should include assessment and management of psychological, social, and spiritual or religious needs.

While respecting patients' **AND THEIR FAMILY'S** wishes for particular treatments when possible, PAs also must weigh their ethical responsibility~~, in consultation with supervising physicians,~~ to withhold futile treatments, and help patients understand such medical decisions. THE SAME IS TRUE FOR EVALUATING A REQUEST TO PROVIDE ASSISTANCE IN DYING.

A PA SHOULD NOT MAKE THESE DECISIONS IN A VACUUM. PRIOR TO TAKING ACTION, ~~**THEY**~~ **THE PA** SHOULD REVIEW INSTITUTIONAL POLICY AND LEGAL STANDARDS. ~~**, AND CONSULT A SUPERVISOR.**~~ A PA ~~**MAY ALSO**~~ **SHOULD ALSO CONSIDER SEEKING** GUIDANCE FROM HOSPITAL ETHICS COMMITTEE, AN ETHICIST, TRUSTED COLLEAGUES, **A SUPERVISOR, OR** OTHER AAPA POLICIES.

~~PAs should involve the physician in all near-death planning. The PA should only withdraw life support with the supervising physician's agreement and in accordance with the policies of the healthcare institution.~~

SEE ALSO, AAPA POLICY PAPER, END-OF-LIFE DECISION MAKING.

The PA and Individual Professionalism

Conflict of Interest

PAs should place service to patients before personal material gain and should avoid undue influence on their clinical judgment. Trust can be undermined by even the appearance of improper influence. Examples of excessive or undue influence on clinical judgment can take several forms. These may include financial incentives, pharmaceutical or other industry gifts, and business arrangements involving referrals. PAs should disclose any actual or potential conflict of interest to their patients.

Acceptance of gifts, trips, hospitality, or other items is discouraged. Before accepting a gift or financial arrangement, PAs ~~might~~ SHOULD consider the guidelines ~~of the Royal College of Physicians, "Would I be willing to have this arrangement generally known?" or~~ of the American College of Physicians, "What would the public or my patients think of this arrangement?" (4)

Professional Identity

PAs should not misrepresent directly or indirectly, their skills, training, professional credentials, or identity. PAs should uphold the dignity of the PA profession and accept its ethical values.

Competency

PAs should commit themselves to providing competent medical care and extend to each patient the full measure of their professional ability as dedicated, empathetic healthcare providers. PROVIDING COMPETENT CARE INCLUDES SEEKING CONSULTATION WITH OTHER PROVIDERS AND REFERRING PATIENTS WHEN A PATIENT'S CONDITION EXCEEDS THE PA'S EDUCATION AND EXPERIENCE, OR WHEN IT IS IN THE BEST INTEREST OF THE PATIENT. PAs should also strive to maintain and increase the quality of their healthcare knowledge, cultural sensitivity, and cultural competence through individual study, ~~**SELF-REFLECTION**~~ **SELF-ASSESSMENT** and continuing education.

Sexual Relationships

It is unethical for PAs to become sexually involved with patients. It also may be unethical for PAs to become sexually involved with former patients or key third parties. THE LEGAL DEFINITION MAY VARY BY JURISTICTION, BUT ~~K~~key third parties are GENERALLY individuals who have influence over the patient~~. These might include~~ SUCH AS spouses or partners, parents, guardians, or surrogates. PAs should be aware of and understand INSTITUTIONAL POLICIES AND LOCAL, state AND FEDERAL laws AND REGULATIONS regarding sexual relationships.

SEXUAL ~~Such~~ relationships generally are unethical because of the PA's position of authority and the inherent imbalance of knowledge, expertise, and status. Issues such as dependence, trust, transference, and inequalities of power may lead to increased vulnerability on the part of the current or former patients or key third parties.

HOWEVER, THERE ARE SOME CONTEXTS WHERE A STRICT MORATORIUM, PARTICULARLY WHEN EXTENDED TO THIRD PARTIES, MAY NOT BE FEASIBLE (3). IN THESE CASES, THE PA SHOULD SEEK ADDITIONAL RESOURCES OR GUIDANCE FROM A SUPERVISOR, A HOSPITAL ETHICS COMMITTEE, AN ETHICIST OR TRUSTED COLLEAGUES. PAS SHOULD SEEK LEGAL COUNSEL WHEN THEY ARE CONCERNED ABOUT THE POTENTIAL LEGAL CONSEQUENCES OF THEIR DECISIONS.

~~Gender Discrimination and Sexual Harassment~~ NONDISCRIMINATION IN THE WORKPLACE AND CLASSROOM

It is unethical for PAs to engage in or condone any form of ~~gender,~~ discrimination. ~~Gender d~~Discrimination is defined as any behavior, action, or policy that adversely affects an individual or group of individuals due to disparate treatment, disparate impact, or the creation of a hostile, INEQUITABLE or intimidating work or learning environment. **THIS INCLUDES,** BUT IS NOT LIMITED TO, **DISCRIMINATION BASED ON ~~GENDER~~, SEX, COLOR, CREED, RACE, RELIGION, AGE, ETHNIC OR NATIONAL ORIGIN, POLITICAL BELIEFS, NATURE OF ILLNESS, DISABILITY, SOCIOECONOMIC STATUS, PHYSICAL STATURE, BODY SIZE, GENDER IDENTITY, MARITAL STATUS, OR SEXUAL ORIENTATION.**

SEE ALSO THE SECTIONS ON NONDISCRIMINATION OF PATIENTS AND FAMILIES, AND SEXUAL HARASSMENT.

SEXUAL HARASSMENT

It is unethical for PAs to engage in or condone any form of sexual harassment. Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature when:

- Such conduct has the purpose or effect of interfering with an individual's work or academic performance or creating an intimidating, hostile or offensive work or academic environment,
- Accepting or rejecting such conduct affects or may be perceived to affect professional decisions concerning an individual, or
- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's training or professional position.

SEE ALSO THE SECTION ON NONDISCRIMINATION IN THE WORKPLACE AND CLASSROOM.

The PA and Other Professionals

Team Practice

PAs should be committed to working collegially with other members of the healthcare team to assure integrated, well-managed, and effective care of patients. PAs should strive to maintain a spirit of cooperation with other healthcare professionals, their organizations, and the general public. THE PA SHOULD CONSULT WITH ALL APPROPRIATE TEAM MEMBERS WHENEVER IT WILL SAFEGUARD OR ADVANCE THE WELFARE OF THE PATIENT. THIS INCLUDES SEEKING ASSISTANCE IN SITUATIONS OF CONFLICT WITH A PATIENT OR ANOTHER HEALTHCARE PROFESSIONAL.

RESOLUTION OF CONFLICT BETWEEN PROVIDERS

WHILE A PA'S FIRST RESPONSIBILITY IS THE BEST INTEREST OF THE PATIENT, IT IS INEVITABLE THAT PROVIDERS WILL SOMETIMES DISAGREE WHEN WORKING AS MEMBERS OF A HEALTHCARE TEAM. WHEN CONFLICTS ARISE BETWEEN PROVIDERS IN REGARDS TO PATIENT CARE, IT IS IMPORTANT THAT PATIENT AUTONOMY AND THE PATIENT'S TRUSTED RELATIONSHIP WITH EACH MEMBER OF THE HEALTHCARE TEAM ARE PRESERVED. IF PROVIDERS DISAGREE ON THE COURSE OF ACTION, IT IS THEIR RESPONSIBILITY TO DISCUSS THE OPTIONS OPENLY AND HONESTLY WITH EACH OTHER, AND COLLABORATIVELY WITH THE PATIENT.

IT IS UNETHICAL FOR A PA TO CIRCUMVENT THE OTHER MEMBERS OF THE HEALTHCARE TEAM OR ATTEMPT TO DISPARAGE OR DISCREDIT OTHER MEMBERS OF THE TEAM WITH THE PATIENT. IN THE EVENT A PA

HAS LEGITIMATE CONCERNS ABOUT A PROVIDER'S COMPETENCY OR INTENT, THOSE CONCERNS SHOULD BE REPORTED TO THE PROPER AUTHORITIES.

PAS SHOULD BE AWARE OF AND TAKE ADVANTAGE OF **AVAILABLE** EMPLOYER RESOURCES~~, IF AVAILABLE,~~ TO MITIGATE AND RESOLVE CONFLICTS BETWEEN PROVIDERS.

Illegal and Unethical Conduct

PAs should not participate in or conceal any activity that will bring discredit or dishonor to the PA profession. They should report illegal or unethical conduct by healthcare professionals to the appropriate authorities.

Impairment

PAs have an ethical responsibility to protect patients and the public by RECOGNIZING THEIR OWN IMPAIRMENT AND identifying and assisting impaired colleagues. "Impaired" means being unable to practice medicine with reasonable skill and safety because of physical or mental illness, loss of motor skills, or excessive use or abuse of drugs and alcohol.

PAs should be able to recognize impairment in ~~physician supervisors, PAs, and other health care providers~~ ANY MEMBER OF THE HEALTHCARE TEAM and should seek assistance from appropriate resources to encourage these individuals to obtain treatment.

SEE ALSO, AAPA POLICY PAPER, PA IMPAIRMENT.

~~**PA–Physician Relationship**~~

~~Supervision should include ongoing communication between the physician and the PA regarding patient care. The PA should consult the supervising physician whenever it will safeguard or advance the welfare of the patient. This includes seeking assistance in situations of conflict with a patient or another healthcare professional.~~

Complementary~~, and~~ Alternative AND INTEGRATIVE HEALTH ~~Medicine~~

When a patient asks about COMPLEMENTARY**, ALTERNATIVE AND/OR ~~HEALTH APPROACHES OR~~** INTEGRATIVE HEALTH **APPROACHES** ~~an alternative therapy~~, the PA has an ethical obligation to gain a basic understanding of the ~~alternative therapy~~ THERAPY(IES) being considered or ~~being~~ used and how the treatment will affect the patient. PAS SHOULD DO APPROPRIATE RESEARCH, INCLUDING SEEKING ADVICE FROM COLLEAGUES WHO HAVE EXPERIENCE WITH THE TREATMENT OR EXPERTS IN THE THERAPEUTIC FIELD. If the PA BELIEVES THE ~~treatment would harm~~ COMPLEMENTARY, ALTERNATIVE OR INTEGRATIVE HEALTH IS NOT IN THE BEST INTEREST OF the patient, the PA should work diligently to dissuade the patient from using it, advise other treatment, and perhaps consider transferring the patient to another provider.

SEE ALSO, AAPA POLICY PAPER: COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)

The PA and the Healthcare System

Workplace Actions

PAs may face difficult personal decisions to withhold medical services when workplace actions (e.g., strikes, sick-outs, slowdowns, etc.) occur. The potential harm to patients should be carefully weighed against the potential improvements to working conditions and, ultimately, patient care that could result. In general, PAs should individually and collectively work to find alternatives to such actions in addressing workplace concerns.

PAs as Educators

All PAs have a responsibility to share knowledge and information with patients, other health professionals, students, and the public. The ethical duty to teach includes effective communication with patients so that they will have the information necessary to participate in their healthcare and wellness.

SEE ALSO, AAPA POLICY PAPER, PA STUDENT SUPERVISED CLINICAL PRACTICE EXPERIENCES - RECOMMENDATIONS TO ADDRESS BARRIERS.

PAs and Research

The most important ethical principle in research is honesty. This includes assuring subjects' informed consent, following treatment protocols, and accurately reporting findings. Fraud and dishonesty in research MUST ~~should~~ be reported TO MAINTAIN THE INTEGRITY OF THE AVAILABLE DATA IN RESEARCH. ~~so that the appropriate authorities can take action.~~

PAS ARE ENCOURAGED TO WORK WITHIN THE OVERSIGHT OF INSTITUTIONAL REVIEW BOARDS AND INSTITUTIONAL ANIMAL CARE AND USE COMMITTEES AS A MEANS TO ENSURE THAT ETHICAL STANDARDS ARE MAINTAINED.

PAs involved in research must be aware of potential conflicts of interest. ~~The patient's welfare takes precedence over the desired research outcome.~~ Any conflict of interest MUST ~~should~~ be disclosed. THE PATIENT'S WELFARE TAKES PRECEDENCE OVER THE PROPOSED RESEARCH PROJECT.

PAS ARE ENCOURAGED TO UNDERGO RESEARCH ETHICS EDUCATION THAT INCLUDES PERIODIC REFRESHER COURSES TO BE MAINTAINED THROUGHOUT THE COURSE OF THEIR RESEARCH ACTIVITY. PAS MUST BE EDUCATED ON THE PROTECTION OF VULNERABLE RESEARCH POPULATIONS.

~~In scientific writing, PAs must should report information honestly and accurately.~~ Sources of funding for the research must be included in the published reports.

THE SECURITY OF PERSONAL HEALTH DATA MUST BE MAINTAINED TO PROTECT PATIENT PRIVACY.

Plagiarism is unethical. Incorporating the words of others, either verbatim or by paraphrasing, without appropriate attribution is unethical and may have legal consequences. When submitting a document for publication, any previous publication of any portion of the document must be fully disclosed.

PAs as Expert Witnesses

The PA expert witness should testify to what ~~he or she~~ THEY believe~~s~~ to be the truth. The PA's review of medical facts should be thorough, fair, and impartial.

The PA expert witness should be fairly compensated for time spent preparing, appearing, and testifying. The PA should not accept a contingency fee based on the outcome of a case in which testimony is given or derive personal, financial, or professional favor in addition to compensation.

SEE ALSO, AAPA POLICY PAPER, GUIDELINES FOR THE PA SERVING AS AN EXPERT WITNESS.

The PA and Society

Lawfulness

PAs have the dual duty to respect the law and to work for positive change to laws that will enhance the health and well-being of the community.

Executions

PAs, as healthcare professionals, should not participate in executions because to do so would violate the ethical principle of beneficence.

SEE ALSO AAPA POLICY HX-4100.1.9.

Access to Care / Resource Allocation

PAs have a responsibility to use healthcare resources in an appropriate and efficient manner so that all patients have access to needed healthcare. Resource allocation should be based on societal needs and policies, not the circumstances of an individual patient–PA encounter. (1) PAs participating in policy decisions about resource allocation should consider medical need, cost-effectiveness, efficacy, and equitable distribution of benefits and burdens in society.

Community Well Being

PAs should work for the health, well-being, and the best interest of both the patient and the community. Sometimes there is a dynamic moral tension between the well-being of the community in general and the individual patient. Conflict between an individual patient's best interest and the common good is not always easily resolved. WHEN CONFRONTED WITH THIS SITUATION, A PA MAY SEEK GUIDANCE FROM A SUPERVISOR, A HOSPITAL ETHICS COMMITTEE, AN ETHICIST, TRUSTED COLLEAGUES, OR OTHER AAPA POLICIES.

In general, PAs should be committed to upholding and enhancing community values, be aware of the needs of the community, and use the knowledge and experience acquired as professionals to contribute to an improved community.

Conclusion

AAPA recognizes its responsibility to aid the PA profession as it strives to provide high quality, accessible healthcare. PAs wrote these guidelines for themselves and other PAs. The ultimate goal is to honor patients and earn their trust while providing the best and most appropriate care possible. At the same time, PAs must understand their personal values and beliefs and recognize the ways in which those values and beliefs can impact the care they provide.

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5. American Medical Association's Code of Medical Ethics. https://www.ama-assn.org/delivering-care/ama-code-medical-ethics
6. AAPA Policy Papers:

   #5. Guidelines for the PA Serving as an Expert Witness (Adopted 1977, reaffirmed 2004, 2009, amended 1987, 1991, 2001, 2014) *Cited at HP-3700.1.5*

   #8 PA Impairment (Adopted 1990, amended 1992, 2009, reaffirmed 2004, 2014) *Cited at HP-3700.1.3*

#12 End-of-Life Decision Making (Adopted 1997, amended 2009, reaffirmed 2004, 2014) *Cited at HP-3700.1.4*

#14 Complementary and Alternative Medicine (Adopted 1999, amended 2005, 2009, reaffirmed 2004, 2014) *Cited at HP-3300.1.14*

#17 Use of Medical Interpreters for Patients with Limited English Proficiency (Adopted 2003, reaffirmed 2008, 2013) *Cited at HP-3300.2.10*

#31 Acknowledging and Apologizing for Adverse Outcomes (Adopted 2007, reaffirmed 2012, amended 2013) *Cited at HP-3800.2.2*

#33 Health Disparities: Promoting the Equitable Treatment of All Patients (Adopted 2011, amended 2016) *Cited at HX-4600.1.6.1*

#38 PA Student Supervised Clinical Practice Experiences - Recommendations to Address Barriers (Adopted 2017) Cited at HP-3200.1.6

#39 Attempts to Change a Minor's Sexual Orientation, Gender Identity, or Gender Expression (Adopted 2017) *Cited at HX-4200.6.2)*

2018-A-14 – Adopted on Consent Agenda

The AAPA House of Delegates will appoint a task force of subject matter experts to develop a policy paper on genetic testing to be presented as a resolution to the 2019 HOD.

2018-A-15 – Adopted on Consent Agenda

Amend policy HP-3700.1.4 entitled "End-Of-Life Decision Making" as follows:

Only sections of the policy paper with proposed amendments are presented. The entire paper can be found in the policy manual.

End-of-Life Decision Making
(*Adopted 1997, amended 2009, reaffirmed 2004, 2014*)

Legal Issues at the End of Life
(22) The following definitions may help to clarify discussions about end-of-life decisions.
(23) **Suicide:** the intentional taking of one's own life.
(24) **Assisted suicide:** providing information, medication (or other means) or direct assistance that enables a person to take ~~his or her~~ THEIR own life. The final action remains with the person who wishes to die.
(25) **Euthanasia:** deliberately bringing about the death of another to spare the individual suffering. In this context, a painless and humane death delivered to a person who is terminally ill.

(26) **Passive euthanasia:** the act of withdrawing support or intervention necessary to keep a patient alive, such as unplugging a ventilator or stopping parenteral feeding.
(27) **Active euthanasia:** direct intervention by another person to cause death, for example, by injecting a lethal dose of a drug.
(28) **Voluntary euthanasia:** performed on a patient who has made clear the wish to die, but is unable to act on it.11
(29) **Double effect euthanasia:** provision of palliative treatment that may have fatal side effects; i.e., steadily rising doses of morphine, intended to control pain and agitation, also "inadvertently" hasten death by depressing respiration.12
(30) **Terminal sedation:** after removal of life sustaining devices, a person is heavily sedated for comfort until death occurs.
(31) **Advance directive:** explicit instructions and guidelines regarding an individual's desires for treatment, comfort, and resuscitative efforts in the event of terminal illness or incapacitation.
(32) Suicide or attempted suicide, while not technically legal, is not prosecuted or punished in any state. All states, however, have prohibitions on intentionally causing the death of another or inducing an individual to commit suicide. At present, assisted suicide is explicitly banned in at least 30 states.13 On March 6, 1996, the first physician-assisted suicide case decided at the federal appellate level found a Washington state ban on physician-assisted suicide to be unconstitutional. The law in question had allowed "passive" withdrawal or withholding of life support, but prohibited "active" assisted suicide. The decision by the US Court of Appeals for the Ninth Circuit affirmed and clarified a 1994 judgment that had declared the state law unconstitutional. In an 8-3 decision, the appellate court stated, “We hold that insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment (to the US Constitution).”14
(33) Less than a month after the Ninth Circuit Court decision, the US Court of Appeals for the Second Circuit struck down a New York law prohibiting assisted suicide. The court found the state had no rational basis for distinguishing between competent, terminally ill patients who may legally choose to refuse medical treatment or have care withdrawn, and patients who choose to end their lives by self-administration of drugs prescribed by their physicians. The court held that “physicians who are willing to do so may prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness.”15
(34) The states of Washington and New York appealed the two circuit court decisions to the US Supreme Court, which heard the case on January 8, 1997. The Supreme Court ruled that terminally ill patients do not have a constitutionally protected right to assisted suicide. The ruling against a constitutional right refers the issue back into state legislatures and courts.16
(35) The risk of criminal liability in withdrawing or withholding life support at the request of a patient or surrogate is exceedingly small. Risk increases somewhat if a clinician directly causes a patient's death by administering a lethal dose of medicine. "Assisting" in a suicide by providing medical advice or means (e.g., a prescription) also carries significant risk of prosecution.18 In 1999, a Michigan court convicted Dr. Jack Kevorkian of second degree murder for administering a lethal injection to a patient suffering from Lou Gehrig’s Disease (People vs. Kevorkian). He was sentenced to 10-25

years' imprisonment. Conviction in such cases is rare if the clinician has acted ethically and compassionately in accordance with the patient's wishes.

(36) Several states have mounted efforts to legalize assisted suicide. A 1991 initiative -- also in the state of Washington -- was defeated in a general election by a 54 to 46% vote. Although the bill's underlying premise seemed to elicit substantial support, there was also strong concern about inadequate safeguards against potential abuse. A year later, a similar initiative in California with broader safeguards was defeated by a similar margin. In 1994, Oregon voters passed a measure permitting a physician to supply a terminally ill patient with a prescription for a lethal amount of drugs, the Death with Dignity Act. The hotly contested bill, which passed by a narrow margin, was actively opposed by the American Medical Association, and its implementation blocked by litigation.19 In 2006, the United States Supreme Court upheld the Oregon Death with Dignity Act in a 6-3 opinion. The court rules that the controlled substances act does not prohibit the use of controlled substances for physician-assisted suicide (Gonzales vs. Oregon no. 04-623).

(37) In 2005, the United States Supreme Court upheld the right of the Florida State Court to order the removal of a feeding tube in the case of Terri Schiavo. It was the sixth time the Supreme Court refused to intervene in the prolonged litigation between the patient's husband and parents.

(38) The debate over assisted suicide points up the distinction between *legalizing* an action and *decriminalizing* it. Legalization makes an action legal in a defined set of circumstances. Decriminalization maintains the prohibition against an action, but reduces the gravity of the charge and the severity of the penalty, usually to a misdemeanor. Absence of criminal liability by no means precludes the possibility of civil liability, such as suits for medical malpractice or wrongful death.

(39) After including safeguards against abuse, in 2008, initiative 1000, the Washington State Death with Dignity Act, was approved by 58% of votes. The law, which closely imitates the Oregon Death with Dignity Act, went into effect March 6, 2009. The act allows a competent adult with a terminal illness to make a written request for medication to be self-administered to end ~~his or her~~ THEIR life. The act includes civil, criminal, and professional disciplinary safeguards for providers who participate in the patient's request.

(40) Another law that has exerted substantial impact on end-of-life decision making is the Patient Self-Determination Act (PL 101-508, 104 Stat 1388-321), enacted as an amendment to Medicare statutes in 1990. This act required states to develop or enact measures to inform patients of their decision making rights regarding treatment, life support, and resuscitation. Details vary from state to state, but the goal of alerting patients to their options regarding advance directives upon admission to a hospital or nursing home has been broadly realized.

Ethical Considerations

(41) Ethics, or principles of moral conduct, are not fixed and static, but subject to change and interpretation. Social, historical, cultural, racial, political, professional, and religious influences all shape the ethical beliefs that affect the actions of health care providers and patients.

(42) Four generally accepted principles of bioethics are autonomy, beneficence, nonmaleficence, and justice.

(43) **Autonomy**, strictly speaking, is self-rule. To be truly autonomous, one must be capable of making decisions and choices.20

(44) **Beneficence** is acting in what is (or is judged to be) the patient's best interest. It is often equated with paternalism.

(45) **Nonmaleficence** means to do no harm, to impose no unnecessary or unacceptable burden upon the patient.

(46) **Justice** means that patients in similar circumstances should receive similar care. It also refers to norms for the fair distribution of resources, risks, and costs.

(47) For centuries, the healing professions, like the clergy, assumed a parental role. Physicians possessed a storehouse of scientific knowledge not accessible to the general public. Their healing endeavors were often cloaked in ritual and quasi-mysticism. Patients were considered incapable of choosing among complicated scientific theories, and physicians were expected to choose for them. Thus emerged the concept of the beneficent healer, and society came to accept medical paternalism and beneficence as one.

(48) Over the past three decades, a gradual but inexorable shift has taken place in the field of bioethics. Patients have become better educated and more capable of understanding scientific data. Medicine has become more accessible and somewhat de-mystified. From the mid-1960s on, authority figures -- physicians included -- have been subject to more challenge and scrutiny. As money has become more a focus of health care decisions and debate, physicians' aura of moral authority has eroded.

(49) In this milieu of change, patient autonomy has evolved as the primary precept of bioethics. In the last 20 years, substantial reforms have been undertaken in the fields of law, ethics, and medical education, all revolving around the patient's right to choose.1 Often, it is assumed that the principles of autonomy and beneficence are in conflict. This is true if one equates beneficence and paternalism, but the terms are not equivalent or interchangeable. In some circumstances, paternalism might be maleficent -- for example, if it violates a patient's right to choose. And beneficence may be far from paternal, since it may consist of educating the patient to enable ~~his or her~~ THEIR informed choice. Beneficence may complement autonomy.

(50) Nonmaleficence as an ethical principle requires that a provider "first, do no harm." This is a tangled issue in end-of-life decision making, since the same acts may be interpreted as harmful or beneficial depending on the circumstances and on participants' values and perspectives. For example, if a comatose patient with no advance directive is kept on life support in the ICU, is not harm inflicted through physical discomfort and financial hardship? On the other hand, if life support is withdrawn, is the patient not harmed by being deprived of even the remotest chance of recovery?

(51) The principle of justice is not a simplistic implication that all patients should receive the same treatments and resources. It does require that all patients be accorded respect for their individuality and autonomy. All should receive the same opportunity to be informed and choose their course of treatment. It also requires that scarce resources be allocated fairly (for example, on patients with a good chance of recovery rather than on those for whom treatment will be futile).21

Cooperative End-of-Life Decision Making

(52) A society's beliefs are reflected in its laws and ethical principles. The individual struggling with difficult decisions about death and dying can turn to those principles for guidance, but will rarely find that they provide all the answers. Ultimately, death is not societal but solitary and supremely personal. However, as medicine has succeeded in prolonging life, greater numbers of people have become enmeshed in the process of an individual's death. At the dying patient's bedside are family, loved ones, clergy, health care providers, technicians and, in absentia, lawyers, ethicists, and even third-party payers. Each brings a set of priorities, beliefs, and values, and achieving complete

harmony among them is usually impossible. If the goal of end-of-life decision making is to make the process of dying as humane and compassionate as possible, it is essential to minimize conflict and maximize cooperation for the patient's benefit. One way to enhance cooperation is by understanding the internal and external influences that affect the patient, ~~his or her~~ THE PATIENT'S family, and clinicians, especially physicians and PAs.

2018-A-16 – Adopted on Consent Agenda

Amend policy HP-3200.1.6 PA entitled "Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers" as follows:

Only the paragraph with a proposed amendment is presented.
The entire paper can be found in the policy manual.

PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers
(Adopted 2017)

One of the most commonly cited concerns among survey participants was the lack of clear understanding about the expectations of precepting a student. While some of these expectations are specific to each program, many aspects of precepting are universal. Respondents repeatedly suggested that a standard precepting toolkit or workshops that guide preceptors in the basic requirements of teaching PA students would be beneficial. This could be achieved through the development of a standardized "PA student passport" or educational checklist that would be common to all PA students and that might include a summary of a student's didactic education and the skills that ~~he or she~~ PA STUDENTS are reasonably expected to perform. This could also be achieved by the implementation of Entrustable Professional Activities (EPAs) into PA education, which will be further discussed in the section on Long-Term Solutions. Survey participants also reported wanting more resources regarding best practices and teaching in a clinical setting.

2018-A-17 – Adopted on Consent Agenda

Amend policy HP-3200.4.1 entitled "Accreditation and Implications of Clinical Postgraduate PA Training Programs" as foolws:

Only sections of the policy paper with proposed amendments are presented.
The entire paper can be found in the policy manual.

Accreditation and Implications of Clinical Postgraduate PA Training Programs
(*Adopted 2005, amended 2010, 2016*)

Executive Summary of Policy Contained in this Paper
Summaries will lack rationale and background information and may lose nuance of policy. You are highly encouraged to read the entire paper.

- AAPA recognizes that advanced training in the clinical setting is a core facet of the professional identity formation and continuing medical education ~~for every PA throughout his or her~~ THROUGHOUT EVERY PA'S career.

Summary

Clinical postgraduate PA training programs represent one of many innovations created by the PA profession to support continuing professional development and lifelong learning, foster interprofessional and collaborative care, advance workforce development and explore novel educational approaches to optimize healthcare delivery. Since 1971, clinical postgraduate PA training programs have provided a relatively small number of interested PAs with diverse opportunities to gain advanced clinical skills and experience in the workplace, building upon the generalist medical education offered to all PAs through entry-level PA education. Similar to the impetus of physician shortages that led to the birth of the PA profession, many of the early clinical postgraduate PA training programs arose to address provider shortages that resulted from duty-hour restrictions of medical residents. Advanced training in the clinical setting is a core facet of the professional identity formation and continuing medical education ~~for every PA throughout his or her~~ THROUGHOUT EVERY PA'S career. Advanced training in the clinical setting, a generalist foundation for entry-level PA education, and generalist model for certification together position the PA profession as one of the most flexible and adaptable professions in modern healthcare. This flexibility and capacity to adopt and adapt to dynamic changes in healthcare delivery make PAs invaluable assets within the U.S. healthcare workforce to improve access and improve the quality of patient-centered care for patients, families, and communities. The development of an efficient, PA-led, national model for accreditation, continuous quality improvement, and reporting on outcomes is needed. Greater investment in research infrastructures is needed to support knowledge generation, dissemination of best practices, and optimization of these voluntary, workplace-based educational innovations for PAs.

2018-A-18 – Adopted on Consent Agenda

Amend policy HP-3300.1.15 entitled "Immunizations in Children and Adults" as follows:

Only sections of the policy paper with proposed amendments are presented. The entire paper can be found in the policy manual.

Immunizations in Children and Adults

(*Adopted 1994, amended 2004, 2006, 2011, 2016*)

- PAs working in primary care should develop systems within their practices to promote optimum immunization of their patients. These systems might include devices such as personal immunization records for patients to carry with them and a way to easily locate each patient's immunization record in ~~his or her~~ THE PATIENT'S medical chart. High-risk patients should be identified and special programs implemented to optimize vaccine coverage, such as mailing a flu vaccine reminder to all high-risk patients every fall.

2018-A-19 – Adopted on Consent Agenda

Amend policy HP-3500.3.3 entitled "Guidelines for Updating Medical Staff Bylaws" as follows:

Only sections of the policy paper with proposed amendments are presented. The entire paper can be found in the policy manual.

Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs
(*Adopted 2012, amended 2017*)

Executive Summary of Policy Contained in this Paper
Summaries will lack rationale and background information, and may lose nuance of policy. You are highly encouraged to read the entire paper.

- AAPA believes PAs must seek the right to exercise clinical privileges via the healthcare entity's organized medical staff process. The process and criteria for a request for medical staff clinical privileges must be outlined in medical staff bylaws.
- AAPA believes PAs should be voting members of the medical staff. Bylaws should afford PA representation with full voting rights on medical staff committees, including the medical executive committee.
- AAPA believes medical staff bylaws should require that each PA wishing to provide medical care to the healthcare entity's patients and seeks to be considered for clinical privileges regardless of the PA's employment arrangements, whether the PA is directly employed by the entity granting the privileges or another independent entity.
- AAPA opposes specialty certification as a requirement for PA credentialing or privileging.
- AAPA believes the duration of medical staff appointments and clinical privileges should be the same for physicians and PAs.
- AAPA believes bylaws should give PAs the right to due process when actions taken by the medical staff or governing board adversely affect ~~his or her~~ THE PA'S clinical privileges.
- AAPA believes the criteria and process for peer review, grievances and corrective actions for PAs should be clearly articulated in the bylaws. The process should involve PA peers and conform to the process applied to physicians.
- AAPA believes bylaws should provide mechanisms to carry out quality assurance with respect to PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the same area of clinical specialty.
- AAPA believes bylaws should require PA participation in continuing medical education that relates to their practice and their privileges.
- AAPA believes bylaws should include language enabling PAs to provide care during emergency or disaster situations, as well as EMTALA specific provisions as required.

Due Process

The bylaws should give the PA the right to request the initiation of due process procedures when actions taken by the medical staff or the governing board adversely affect ~~his or her~~ THE PA'S clinical privileges. The Medicare Conditions of Participation for Hospitals Interpretive Guidelines11 as well as accreditation standards from the Joint Commission12 specifically require a fair hearing and appeals process for addressing adverse

decisions made against medical staff members and others holding clinical privileges. The process should include PA peer reviewers.

Participation in Disaster and Emergency Care

The bylaws should include language enabling PAs to provide care during emergency or disaster situations. The bylaws should state that the chief executive or ~~his or her~~ THE CHIEF EXECUTIVE'S designee may grant temporary clinical privileges when appropriate and that emergency privileges may be granted when the hospital's emergency management plan has been activated. The hospital's emergency preparedness plan should include PAs in its identification of care providers authorized to respond in emergency or disaster situations.

Bylaws language might state:

In case of an emergency, any member of the medical staff, house staff, and any licensed health practitioner, limited only by the qualifications of their license and regardless of service or staff status, shall be permitted to render emergency care. They will be expected to do everything possible to save the life of a patient, utilizing all resources of the hospital as necessary, including the calling of any consultations necessary or desirable. Any PA or physician acting in an emergency or disaster situation shall be exempt from the hospital's usual bylaws provisions to the extent allowed by state law in disaster or emergency situations.

Conclusion

- PAs must seek delineation of their clinical privileges. The process and criteria for which must be outlined in medical staff bylaws.
- PAs should be voting members of the medical staff.
- Medical staff bylaws should require that each PA be granted clinical privileges to provide medical care to patients in the facility, regardless of by whom that PA is employed.
- AAPA opposes specialty certification examinations as a requirement for PA credentialing or privileging.
- Duration of appointments and privileges should be the same for physicians and PAs.
- Bylaws should give PAs the right to due process when actions taken by the organized medical staff or governing board adversely affect ~~his or her~~ THE PA'S clinical privileges.
- The criteria and process for corrective action should be spelled out for PAs in the bylaws. The process should involve PA peers and conform to the process applied to physicians
- Bylaws should provide mechanisms to carry out quality assurance with respect to PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the same area of clinical specialty.
- Bylaws should require PA participation in continuing medical education that relates to their practice and their privileges.
- Bylaws should allow PA representation on standing medical staff committees, including the medical executive committee, credentialing committees, and others.
- Bylaws should include language enabling PAs to provide care during emergency or disaster situations.

2018-A-20 – Adopted on Consent Agenda

Amend policy HP-3500.4.1 as follows:

AAPA opposes the use of non-compete clauses in PA's employment contracts. These covenants violate a PA's right to practice ~~his or her~~ THEIR profession, negatively impact various aspects of patient care and access to care, and ultimately put financial interests ahead of patient and community care.

2018-A-21 – Adopted on Consent Agenda

Amend policy HP-3700.1.3.2 as follows:

AAPA shall support in principle the chemically dependent PA who has acknowledged ~~his/her~~ THEIR illness, engaged in a recovery program, and persists in a lifestyle compatible with ongoing recovery.

2018-A-22 – Adopted as Amended

Amend policy HX-3700.1.5 entitled "Guidelines for the PA Serving as an Expert Witness".

Guidelines for the PA Serving as an Expert Witness

(Adopted 1977, reaffirmed 2004, 2009, amended 1987, 1991, 2001, 2014)

Only sections of the policy paper with proposed amendments are presented here. The entire paper can be found in the policy manual.

Executive Summary of Policy Contained in this Paper

Summaries will lack rationale and background information and may lose nuance of policy. You are highly encouraged to read the entire paper.

- A PA serving as an expert witness should have current experience and knowledge in the area(s) about which ~~he or she~~ THE PA is to testify.
- A PA expert must objectively evaluate facts and provide an opinion. If no opinion can be derived from available facts, this should be stated to the attorney.
- The PA's review of medical facts should be thorough, fair, and impartial and should not exclude any relevant information in order to create a view favoring either the plaintiff or the defendant. The ~~expert~~ PA SERVING AS AN EXPERT WITNESS should champion what ~~he or she~~ THE PA believes to be the truth.
- A PA giving testimony does not attack performance that which falls within accepted standards of practice or support obviously deficient practice.
- A PA offering an opinion should know what constitutes customary practice. Testimony about innovation in medical practice should be identified as such.
- The PA should testify truthfully and consistently, recognizing his or her testimony may be subject to peer review.
- The PA should not accept a contingency fee – compensation based on the outcome of a case in which testimony is given – or derive personal, financial, or professional favor in addition to compensation.

Introduction

A PA may serve as a witness in a legal proceeding in one of several capacities.1 These guidelines discuss serving as expert witness and giving opinions in professional liability (medical malpractice) cases. Accompanying notes and references outline other

roles a PA may have as a witness or consultant, preparation for testifying, legal terms, strategies and tactics that may be encountered.

It is the intent of the Academy to inform PAs about the duties PAs have, as health care professionals, to society, the legal system, and the profession. These guidelines and comments are not legal advice. PAs involved in legal matters are urged to obtain legal advice from a qualified attorney.

A PA may be called upon or directed to give an expert medical opinion in the judicial system because knowledge about medicine and PA practice is generally considered beyond the average judge or juror's experience. A patient who alleges injury (plaintiff) and the judge or jury will need opinions about standards of medical care, if and how a standard of care was met, and, if not, how falling below a standard caused injury to the patient. The practitioner (defendant) may also need expert opinions and may serve as an expert witness in his or her own behalf.

The responsibility of providing a professional opinion as an expert witness should be undertaken after careful self-evaluation and thorough preparation with an attorney. The PA should have an understanding of medical, legal and ethical principles involved.2

Guideline 1: A PA serving as an expert witness should have current experience and knowledge in the area(s) about which ~~he or she~~ THE PA is to testify.3

A PA's knowledge and experience alone may not sufficiently satisfy an attorney or qualify the PA to testify in court as an expert witness. Maturity, integrity, composure and other personal characteristics should be evaluated with an attorney prior to offering testimony. Prior testimony, income from testifying, potential conflicts of interest with, or bias toward, other parties involved in the case may render a PA unsuitable as a witness. If, after meeting with an attorney, the PA is unclear on issues about which ~~he or she~~ THE PA will testify, feels uncomfortable offering an opinion, or has no opinion, voluntary testimony should not be given.

Guideline 2: A ~~PA expert~~ PA SERVING AS AN EXPERT WITNESS must objectively evaluate facts and provide an opinion. If no opinion can be derived from available facts, this should be stated to the attorney. The PA's review of medical facts should be thorough, fair, and impartial and should not exclude any relevant information in order to create a view favoring either the plaintiff or the defendant. The PA SERVING AS AN expert WITNESS should champion what ~~he or she~~ THE PA believes to be the truth.

PAs serving as expert witnesses have an ethical responsibility to the profession. The Guidelines for Ethical Conduct for the PA Profession admonishes a PA from participating in an activity that will discredit or dishonor the profession. Providing an expert opinion in a judicial process is never a trivial matter. There are risks to the witness, profession, other parties, and society. Yet, AAPA Policy further asks PAs to expose without fear or favor, any illegal or unethical conduct in the medical profession. Participating in a judicial proceeding as an expert witness, like peer review, is a necessary obligation of the profession and its members. Expert opinion may support or criticize a colleague.

This duty, to serve for the good of society and the courts, is a guiding principle. This responsibility may override the concept that PAs should act, in these situations, as advocates for a patient or serve only a patient's interest. Expert opinion may help or hinder a patient's cause.

Guideline 3: It is incumbent upon a PA giving testimony in legal proceedings that his or her testimony does not attack performance that falls within accepted standards of practice or, conversely, support obviously deficient practice. Since experts establish the standards of practice in a given case, care should be exercised to ensure that such standards do not narrowly reflect the experts' views to the exclusion of other acceptable choices.

An expert witness should recognize that there is uncertainty inherent in medical practice. It is a dynamic and changing discipline based on concepts of probability rather than on absolute certainty. Principles drawn from the experience of a number of patients and providers are applied to individual patients with hope for success. Further, with technologically advanced medical care, both benefits and risks are likely to be increased. Risks of complication in the practice of technical specialties can be frequent and/or severe. In providing expert testimony, a PA should have in mind a clear distinction between the occurrence of unavoidable and/or severe complications which do not represent malpractice (good medical care, but a bad outcome), and the occurrence due to negligence4 (poor medical care that contributes to or causes a bad outcome).

Testimony is usually given concerning customary or standard practice. Innovation in medical practice is sometimes considered in a legal proceeding. An innovation may or may not fall outside of the standard of care. Many advances in medical practice rely on innovation.

Guideline 4: A PA offering an opinion should know what constitutes customary practice. Testimony about innovation in medical practice should be identified as such.

A PA may offer an expert opinion several times in one legal proceeding or in several separate proceedings. Expert testimony offered by the PA in previous cases and proceedings is often reviewed and compared by attorneys and other experts. All testimony should be truthful and consistent.

Guideline 5: The PA should testify truthfully and consistently, recognizing his or her testimony may be subject to peer review.

Custom and rules governing compensation for legal witnesses vary. The PA should be fairly compensated for time spent preparing, appearing and testifying as an expert witness.

Guideline 6: The PA should not accept a contingency fee — compensation based on the outcome of a case in which testimony is given — or derive personal, financial, or professional favor in addition to compensation.

Summary of Academy
Guidelines for the PA Serving as an Expert Witness

The PA should have current experience and ongoing knowledge in the areas of clinical practice about which ~~he or she~~ THE PA is testifying.

The PA should objectively evaluate the facts and provide an opinion. The PA's review of medical facts should be thorough, fair and impartial and should not exclude any relevant information in order to create a view favoring either the plaintiff or the defendant. The PA SERVING AS AN expert WITNESS should champion what ~~he or she~~ THE PA believes to be the truth, not the cause of one party in a dispute.

2018-A-23 – Adopted on Consent Agenda

Amend policy HX-3700.3.2 entitled "Licensure Eligibility for PAs Trained Abroad" as follows:

Only sections of the policy paper with proposed amendments are presented. The entire paper can be found in the policy manual.

Licensure Eligibility for PAs Trained Abroad
(Adopted 2004, amended 2009, reaffirmed 2014)

Only sections of the policy paper with proposed amendments are presented here. The entire paper can be found in the policy manual.

Licensure Requirements for PAs Trained Abroad

AAPA believes that the following represents a framework for PAs trained abroad who wish to become licensed in the United States.

- A visa screening or credentialing organization, such as the Commission on Graduates of Foreign Nursing Schools or other recognized entity, should verify the PA education, PA licensure, experience, and English proficiency of non-U.S. citizen PAs trained abroad, as is currently required by federal law for international health care workers, entering the United States.
- PAs trained abroad should apply for acceptance at an ARC-PA accredited entry level PA program. They should present evidence of their prior education and experience and request credit for coursework completed.
- Entry level PA programs should consider applications from PAs trained abroad and offer advanced standing, if appropriate, to those who meet their admission criteria.
- The education for these individuals in U.S. PA programs is envisioned to include four components:
    - o Credit for some of the coursework and/or rotations done in their own country and/or in the United States;
    - o Didactic coursework in those areas for which they did not receive advanced standing;
    - o Mandatory didactic coursework about physician-PA role and team practice and standards of care in the United States;
    - o Clinical rotations.
- Only those programs with the interest and resources necessary to handle this complement of students should do so. Those that lack the faculty or clinical rotations or that would face state or institutional barriers would not have to offer this educational experience to PAs trained outside the United States.

In summary, non U.S. citizen PAs trained abroad who wish to enter the U.S. for the purposes of working as PAs should have their education, experience, license, and English proficiency verified by CGFNS or another approved visa screening organization. They would submit their certification with their visa applications. If granted visas, they would come to the U.S., where they would apply for admission to an accredited PA program. Programs that choose to accept these individuals, including American citizens who have obtained PA training abroad, can apply their own admission criteria and may

consider granting advanced standing to the limits established by the program's sponsoring institution. After admission and graduation from an accredited PA program, these individuals would be eligible to sit for the PANCE. Passage of the PANCE would make them eligible for state licensure.

This system is similar to the one that exists for physicians (see Appendix 2) in that it requires additional supervised education in the U.S. Completion of this education would be followed by a requirement to take the same NCCPA examination that is given to U.S. graduates prior to licensure.

The proposal described above does not necessarily require every PA trained abroad to repeat ~~his or her~~ THEIR entire education after arriving in this country. AAPA believes it is appropriate to evaluate separately each individual who has received PA education outside the U.S. and to give credit for coursework and/or rotations completed in their own country or in the U.S.

AAPA acknowledges that there are cultural and educational differences among the countries of the world, and that the knowledge needed to practice according to the standards of care of each country can vary substantially. That is why the Academy recommends that PAs trained abroad seeking licensure be required to have additional supervised clinical education at an accredited entry-level PA program and be taught more about the PA role as part of physician-led teams in the U.S. health care system.

The Academy hopes, with the adoption of this document, that other countries will adopt similar practice requirements for American PAs who wish to work abroad. While American PAs may have much to contribute, it is essential to respect cultural differences and values and to be knowledgeable about health system norms, allocation of resources, and treatment of conditions common to the population before working in another country.

Appendix 1. Immigration Procedures for Foreign Health Care Workers

Immigration law requires that individuals wishing to enter the United States on either a temporary or permanent basis must apply to the U.S. State Department for a visa. There are two major categories of visas: non-immigrant and immigrant. Non-immigrant visas are given to individuals who wish to come to the U.S. on a temporary basis and for a specific purpose. There are approximately 60 different non-immigrant visa classifications, in areas such as business, education, pleasure, and temporary work. Immigrant visas are given to individuals who intend to live and work permanently in the U.S. These visas are either family- or employment-based.

The law specifies the documentation that must accompany visa applications. For example, individuals applying for H-1B visas (temporary work in a specialty occupation such as law or engineering) must submit evidence regarding education or experience and qualifications. In some cases, a permanent or temporary state license to practice must be obtained prior to approval of the visa application.

There are specific provisions in the law regarding foreign physicians and nurses. In 1996, Congress amended the Immigration and Nationality Act to add, among other things, provisions related to other foreign health care workers. The 1996 amendments require all immigrants and non-immigrants coming to the U.S. as health care workers to be screened and certified by the Commission on Graduates of Foreign Nursing Schools (CGFNS) or an equivalent independent credentialing organization approved by the U.S. Attorney General. Health care workers are defined as physical and occupational therapists, medical technicians and clinical laboratory scientists, speech language pathologists and audiologists, and PAs.

The screening organization must verify that the alien's education, training, license, and experience are comparable to those required for an American health care worker of the same type; that they are authentic, and, in the case of a license, unencumbered. The foreign health care worker must also have an appropriate level of proficiency in written and spoken English. If the majority of states licensing the profession in which the alien intends to work recognize a test that predicts an applicant's success on the profession's licensing or certification examination, then the alien must have passed that test.

Anyone who meets these criteria is given a certificate that becomes part of ~~his or her~~ THE FOREIGN HEALTH CARE WORKER'S visa application.

2018-B-01 – Adopted as Amended

Amend policy HP-3100.1.3 as follows:

AAPA DISCOURAGES THE USE OF TERMS SUCH AS MIDLEVEL PROVIDERS, PHYSICIAN EXTENDERS, **ALLIED HEALTH PROFESSIONALS** OR ANY OTHER TERMS THAT DEVALUE PAS' CONTRIBUTION TO HEALTHCARE.

2018-B-02 – Adopted as Amended

~~AAPA believes the terms "advanced practice provider" and "advanced practice clinician" should only be representative of REFER **ONLY** TO ARE APPROPRIATE TERMINOLOGY TO USE TO DESCRIBE COLLECTIVE WORK OF PAs and APRNs in a healthcare system or practice.~~

AAPA BELIEVES WHENEVER POSSIBLE, PAS SHOULD BE REFERRED TO AS PAS. AAPA RECOGNIZES ENTITIES MAY USE THE TERMS "ADVANCED PRACTICE PROVIDERS" OR "ADVANCED PRACTICE CLINICIANS" WHICH SHOULD ONLY REFER TO PAS AND APRNS.

2018-B-03 – Adopted

Amend policy HP-3100.1.3.1 as follows:

PAs should ~~utilize, and~~ encourage employers ~~(e.g., hospitals, HMO's, clinics)~~, third party payers, educators, researchers, and the government to utilize the term "PA" OR "physician assistant" ~~or "PA"~~ to INCREASE TRANSPARENCY AND VISIBILITY ~~unique position~~ of PAs ~~in~~ THROUGHOUT the healthcare system.

2018-B-04 – Adopted

Amend policy HP-3200.3.5 as follows:

AAPA shall continue to educate and serve as a resource to students, programs, and graduate PAs on issues concerning reimbursement for ~~physician~~ MEDICAL services provided by PAs.

2018-B-05 – Adopted as Amended

Amend policy HP 3400.1.3 as follows:

AAPA supports expanded healthcare access for all people. AAPA encourages innovation in healthcare delivery~~, but remains~~ AND IS committed to the model of **INTERPROFESSIONAL ~~MULTIDISCIPLINARY~~** ~~physician directed~~ team care. AAPA maintains that continuity of care is a high priority; therefore, communication between the episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality and patient preference.

2018-B-06 – Referred (to be referred by the Speaker to the appropriate body and reported back to the 2019 HOD)

Amend policy HP-3500.1.2 as follows:

AAPA recognizes that many federal PAs are exempt from state licensing laws and regulations and are subject to PA criteria established by their federal agencies, THE FEDERAL OFFICE OF PERSONNEL MANAGEMENT AND/or by Congress. These federal requirements SET BY THE OFFICE OF PERSONNEL MANAGEMENT, WHICH APPLY TO MANY FEDERAL PAS~~,~~ include:

1) graduation from a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) OR ITS PREDECESSORS, AT A COLLEGE, UNIVERSITY OR EDUCATIONAL INSTITUTION THAT IS ACCREDITED BY AN ACCREDITING BODY OR ORGANIZATION RECOGNIZED BY THE U.S. DEPARTMENT OF EDUCATION AT THE TIME THE DEGREE WAS OBTAINED,

2) ~~, or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation (CAHEA), or the Commission on Accreditation of Allied Health Education Programs [CAAHEP]), and/or~~ passage of the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA), ~~and~~

3) continual maintenance of national certification, AND

4) UNRESTRICTED LICENSE OR REGISTRATION AS A PHYSICIAN ASSISTANT FROM A STATE. ~~when required by the federal agency.~~

MANY PAS CURRENTLY PRACTICING FOR THE FEDERAL GOVERNMENT ARE NOT CURRENTLY REQUIRED TO HAVE A STATE LICENSE. ~~Therefore,~~ ~~t~~The Academy believes that federal PAs should not be required to have a state license to obtain full practice privileges (including prescribing), to be credentialed in a federal facility, or to participate in a federal activity such as a disaster medical team.

THE ACADEMY BELIEVES FEDERALLY EMPLOYED PAS SHOULD NOT BE REQUIRED TO MAINTAIN NATIONAL CERTIFICATION AS A REQUIREMENT

OF EMPLOYMENT. ~~In states where federal-state requirements do not conflict; federal PAs may hold state licenses.~~

Any federalLY EMPLOYED PA SHOULD BE ABLE TO ~~may~~ opt to hold a state license.

2018-B-07 – Adopted on Consent Agenda

Amend policy HP-3600.1.5 as follows:

AAPA believes ~~that~~ services provided by PAS ~~physician-PA teams~~ should be counted when federal and state governments determine the primary healthcare service needs of medically underserved and health professional shortage areas. Recognition of PA ~~physician-PA team~~ productivity should not be done in such a way as to decrease patient access to care.

2018-B-08 – Adopted on Consent Agenda

Amend policy HX-4500.3 as follows:

AAPA believes ~~that~~ TO ENSURE ACCOUNTABILITY FOR THE PROVISION OF CARE PROVIDED BY EACH MEMBER OF THE HEALTHCARE TEAM, electronic health record (EHR) systems, computerized provider order entry (CPOE) systems, reimbursement and claims systems, and other health information technology systems should individually recognize and APPROPRIATELY ATTRIBUTE PA-PROVIDED PATIENT CARE DATA TO INDIVIDUAL PAS. ~~support the optimal utilization of PAs, and, when appropriate, provide attribution to PAs.~~

Health information technology systems should be designed, developed, and implemented with ~~appropriate~~ PA input in a manner that benefits patients, ~~the physician-PA team~~ PAS, and the healthcare ~~system~~ TEAM by improving quality, TRANSPARENCY AND ACCURACY. ~~encouraging patient-centered care, and reducing costs.~~

2018-B-09 – Adopted

Amend policy HX-4600.1.3 as follows:

AAPA BELIEVES ~~C~~coverage for the treatment of mental health and substance use disorders should be available, nondiscriminatory and covered at the same benefit level as other medical care.

AAPA BELIEVES ~~R~~reimbursement for PAs providing mental health and substance use disorder care should be provided in the same manner as other MEDICAL ~~physician~~ services provided by PAs.

AAPA BELIEVES NO INSURANCE COMPANY, THIRD-PARTY PAYER OR HEALTH SERVICES ORGANIZATION SHALL IMPOSE A PRACTICE,

EDUCATION OR COLLABORATION REQUIREMENT THAT IS INCONSISTENT WITH OR MORE RESTRICTIVE THAN EXISTING PA STATE LAW.

2018-B-10 – Adopted on Consent Agenda

Amend policy HP-3300.2.10 entitled "Use of Medical Interpreters for Patients with Limited English Proficiency" as follows:

Use of Medical Interpreters for Patients with Limited English Proficiency
(*Adopted 2003, reaffirmed 2008, 2013*)

Executive Summary of Policy Contained in this Paper
Summaries will lack rationale and background information, and may lose nuance of policy. You are highly encouraged to read the entire paper.

- PAS HAVE AN ETHICAL AND LEGAL OBLIGATION TO USE APPROPRIATELY TRAINED MEDICAL INTERPRETERS FOR THEIR PATIENTS WITH LIMITED ABILITY TO SPEAK OR UNDERSTAND ENGLISH.

PAs provide vitally important services to patients. The effectiveness of the care delivered by PAs depends heavily on the establishment of a PA-patient relationship based on empathy, confidence, trust, and the free flow of communication. The exchange of information can be difficult when the two parties involved speak different languages.

Language difficulties have been identified as one of the leading barriers to obtaining effective health care in the United States(1). The number of people in the United States with limited English proficiency (LEP) is increasing. ~~Recent~~ THE 2016 census data showS that ~~44~~ 65.5 million ~~Americans~~ INDIVIDUALS speak a language other than English at home(2).

Based on Title VI of the 1964 Civil Rights Act, which promises equal access to federally assisted programs and activities to everyone in the United States, the Office of Civil Rights (OCR) of the Department of Health and Human Services issued a policy guidance ~~in August 2000~~ that affects PAs and other health care providers(3) ~~(see http://www.hhs.gov/ocr/lep/guide.html~~ the document clarifies a requirement that recipients of federal assistance provide translation services at no cost to people whose ability to read, speak, or understand English is limited. This means that health care providers who accept Medicare and Medicaid payment for their services to LEP patients should provide them with effective language assistance. The goal is to make sure that all patients receive quality medical care, even in circumstances where a health care professional and a patient speak different languages.

It is a challenge to determine how to overcome the communication barrier that could leave patients without adequate or appropriate medical attention. Because the diversity of health care providers does not match, either ethnically or geographically, the diversity of the patient population, the use of qualified medical interpreters is a critical part of the solution.

Competent medical interpretation requires a specialized set of skills that extends beyond the knowledge of two languages. The use of an interpreter who lacks the competency to accurately convey technical information can lead to misdiagnoses and

inappropriate treatments(4). It also places health care providers at greatly increased legal risk. There are significant drawbacks to using a patient's friends or family, especially children, as interpreters. These include the likelihood of inaccurate translations, omissions, additions, substitutions, volunteered answers, personal opinions, and other problems. The use of untrained interpreters also increases the risk of breaching patient privacy and confidentiality requirements(5).

Trained, professional medical interpreters are held to high standards by codes of ethics to which they must adhere(6). This helps preserve the confidentiality of patient information. In addition, professional interpreters should be able to provide not only accurate translations, but also culturally and socially informed explanations.

The Office of Civil Rights requires health care providers with publicly-assisted LEP patients to have reasonable policies and procedures in place(3). This may include hiring bilingual staff who are trained and competent interpreters, hiring staff interpreters, contracting with an outside interpreter service, arranging for the services of voluntary community interpreters, and using a telephone language interpreter service. Patients may be referred to nearby facilities that have translators, but providers are obligated to follow up to make sure that appropriate care is given. Written materials that are routinely provided to patients, such as consent forms and medication instructions, must be translated. LEP patients must also be notified of their right to free language assistance. OCR says that friends, family, and minor children may be used as interpreters only after patients have been informed of their right to free translation services and have declined their use.

OCR requires that covered providers ensure that they are using competent interpreters. Interpreters may hold formal certification. Alternatively, they may prove their competence through demonstrated proficiency in both English and the other language, orientation and training that includes the skills and ethics of interpreting, fundamental knowledge in both languages of any specialized terms or concepts, sensitivity to the LEP patient's culture, and the ability to convey information in both languages accurately.

The requirements of assuring interpreter competency and underwriting the cost of providing interpreter services are two stumbling blocks to full and effective implementation of the OCR guidance. Nevertheless, compliance is required by all covered providers. OCR investigates all complaints, reports, or other information that allege or indicate noncompliance with Title VI of the Civil Rights Act. OCR will provide technical assistance, consultation, and reasonable timetables in such cases, but failure to resolve the problem could result in exclusion from the Medicare or Medicaid program, referral to the Department of Justice for enforcement proceedings, or other actions.

The Guidelines for Ethical Conduct for the PA Profession are clear in their emphasis on PA-patient relationships; respect for dignity, confidentiality, and diversity; non-discrimination; informed consent; and other principles that come into play when treating LEP patients. ~~PAs thus have an ethical and legal obligation to use appropriately trained medical interpreters for their patients with limited ability to speak or understand English.~~

SUMMARY

AN INCREASING PROPORTION OF THE POPULATION OF THE UNITED STATES IS NOT FLUENT IN ENGLISH. WHEN IT COMES TO PROVIDING HEALTH CARE, IT IS APPROPRIATE TO USE MEDICAL INTERPRETERS THAT ARE NOT ONLY FLUENT IN THE LANGUAGE, BUT ALSO CULTURALLY

AWARE IN ORDER TO PROVIDE THE MOST ACCURATE INTERPRETATION POSSIBLE. THIS IS IMPORTANT FROM AN ETHICAL STANDPOINT BUT ALSO A MEDICOLEGAL ONE, AND MANDATED BY FEDERAL REGULATIONS.

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2018-B-11 – Adopted as Amended

AAPA supports and encourages awareness and recognition of professional burnout in all healthcare providers and education on the prevention of burnout. AAPA supports and encourages all healthcare providers to engage in ~~self-care as part of burnout prevention.~~ A COMPREHENSIVE MULTI-PRONGED STRATEGY FOR PREVENTION OF PROFESSIONAL BURNOUT.

2018-B-12 – Adopted on Consent Agenda

AAPA opposes any mandatory policy, regulation or restriction in state or federal law that limits the number of PAs and physicians that can form collaborative relationships. AAPA believes that the number of PA and physician collaborative relationships should be determined at the practice level.

2018-B-13 – Adopted

Amend policy HP-3800.2.2 entitled **"**Acknowledging and Apologizing for Adverse Outcomes" as follows:

Acknowledging and Apologizing for Adverse Outcomes
(Adopted 2007, reaffirmed 2012, amended 2013)

Executive Summary of Policy Contained in this Paper
Summaries will lack rationale and background information, and may lose nuance of policy. You are highly encouraged to read the entire paper.

~~Improving healthcare quality and reducing preventable adverse events in care delivery continue to be a top priority for the United States health care system. Since the Institute of Medicine (IOM) published its 1999 report titled "To Err is Human: Building a Safer Health System," emphasis and effort in reducing preventable injury and improving care delivery have taken place. Further, the discipline of disclosure of medical error has seen significant advancement.~~

- AAPA believes that patients deserve complete and honest explanations of adverse outcomes and apologies for medical mistakes.
- AAPA also supports not only the current science around disclosure and apology during care delivery, but also encourages PAs to be active participants in local disclosure programs.
- AAPA commits to providing education to PAs and advancing the science of medical error disclosure.

Disclosing Errors

IMPROVING HEALTHCARE QUALITY AND REDUCING PREVENTABLE ADVERSE EVENTS IN CARE DELIVERY CONTINUE TO BE A TOP PRIORITY FOR THE UNITED STATES HEALTH CARE SYSTEM. SINCE THE INSTITUTE OF MEDICINE (IOM) PUBLISHED ITS 1999 REPORT TITLED "TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM," EMPHASIS AND EFFORT IN REDUCING PREVENTABLE INJURY AND IMPROVING CARE DELIVERY HAVE TAKEN PLACE. FURTHER, THE DISCIPLINE OF DISCLOSURE OF MEDICAL ERROR HAS SEEN SIGNIFICANT ADVANCEMENT.

The IOM'S 1999 REPORT ~~has previously~~ reported that as many as 98,000 people die each year as a result of medical error (1). A 2016 STUDY BY RESEARCHERS AT JOHNS HOPKINS MEDICINE PUBLISHED IN BMJ EXPANDED THE NUMBER TO 251,000 DEATHS PER YEAR, MAKING MEDICAL ERRORS THE THIRD LEADING CAUSE OF DEATH IN THE U.S. BEHIND CARDIAC DISEASE AND CANCER (2). Adverse outcomes can occur in any health care setting, including inpatient, outpatient, home and long-term care (~~2~~3). Further, preventable harm from care delivery impacts not only patients, but families, caregivers, staff and communities (~~2~~3).

Health care organizations that establish a culture of quality and safety are more likely to proactively identify a crisis management plan. These plans include processes that enhance communication between and among all stakeholders (~~2~~3). Thus, every health care organization should establish a plan to address adverse events. The response should be prioritized to include 1) the patient and family; 2) the frontline staff, and; 3) the

organizational response (i.e. initiate root cause analysis and crisis management team) (~~2~~3).

The Patient and Family

The patient and family must be the priority of the health care organization and the provider before, during and after an adverse event (~~2~~3). Disclosing medical errors respects patient autonomy and truth-telling, is desired by patients, and has been endorsed by many ethicists and professional organizations (4).[~~4~~] According to ~~the~~ AAPA'S ~~"~~Guidelines for Ethical Conduct for the PA Profession,~~"~~ PAs ~~"~~should disclose errors to patients if such information is significant to the patient's interests and well-being. As disclosure science in health care continues to develop, much of the data generated highlights the fundamental importance of openly admitting error (~~4~~5). A number of studies suggest that both the public and health care professionals generally agree that medical errors causing harm should be disclosed to the patient, an apology rendered, and, IN SOME CASES, fair compensation be negotiated. This process has demonstrated a reduction in litigation costs and has been widely adopted by health systems both academic and federal (~~5~~6).

The Frontline Staff

Health care staff can become the "second victims' of adverse events (~~2~~3). This may occur secondary to blaming behaviors, damage to personal or professional reputation, and unresolved feelings of sorrow and loss (~~2~~3). Organizations with an existing crisis management plan, a shared process of root cause analysis and culture of inclusion promote patient-centered quality and safety (~~2~~3).

The Organizational Response

The culture of safe and high-quality health care begins with the organizational leader, who proactively develops a crisis management plan and assumes shared responsibility when adverse events take place (~~2~~3). Following an adverse event, it is critical for leaders to include all stakeholders in the root cause analysis (~~2~~3). This process enhances communication, promotes healing and ensures learning takes place (~~2~~3). Most importantly, leadership must ensure that the patient and family are clearly informed throughout the process of the investigation (~~2~~3).

Policy and Legislation

To counter the perceived risk of increased liability, a ~~number~~ MAJORITY of states have adopted ~~or are considering~~ apology laws that exempt ALL OR SOME expressions of regret, sympathy, or compassion from being considered as admissions of liability in medical malpractice lawsuits (7, 8).[~~16~~] ~~Federal legislation has also been drafted that promotes medical error reporting, disclosure to patients, apology, and, in cases when the standard of care is not met, offers of compensation. This legislation is based on the principles of~~

The Sorry Works! Coalition, AN ADVOCATE FOR LEGISLATIVE, POLICY AND CULTURAL CHANGE ~~which~~ believes that full disclosure addresses the root cause of the medical malpractice crisis better than any other approach currently under consideration (9). THE COALITION TEACHES HEALTHCARE, INSURANCE, AND LEGAL PROFESSIONALS HOW TO STAY CONNECTED WITH PATIENTS AND FAMILIES AFTER ADVERSE MEDICAL EVENTS WITH A THREE-STEP PROCESS OF EMPATHY, REVIEW, AND RESOLUTION (10). ~~According to the coalition, Sorry Works! restores the provider-patient relationship and improves the communication and trust between all parties, thus reducing the filing of non-meritorious claims and saving on legal expenses.~~[~~13~~]

While the coalition believes that legislative action or mandates are not necessary preconditions for implementation of a full disclosure program, THEY RECOGNIZE THAT SOME ~~others~~ prefer the security provided by legislation that reduces liability.

Conclusion

In the spirit of patient-centered care, AAPA believes that patients deserve complete and honest explanations of adverse outcomes and apologies for medical mistakes. AAPA also supports not only the current science around disclosure and apology during care delivery, but also encourages PAs to be active participants in local disclosure programs.

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2018-B-14 – Adopted as Amended

The AAPA HOD requests that the Board of Directors contract with APPROPRIATE independent ~~marketing/PR~~ CONSULTING/RESEARCH firmS to investigate STATE/FEDERAL, FINANCIAL, POLITICAL, BRANDING ASPECTS, AND ALTERNATIVES TO the creation of a new professional title for physician assistants that accurately reflects AAPA PROFESSIONAL PRACTICE POLICIES ~~these provider's present and future utilization and practice abilities~~, reporting the results to the 2019 HOD.

2018-B-15 – Rejected

Amend policy HP-3500.3.4 entitled "Guidelines for State Regulation of PAs" to add language more clearly emphasizing that Optimal Team Practice (OTP) is not intended to establish the independent practice of medicine by PAs thereby addressing the concerns of organized medicine as follows:

Guidelines for State Regulation of PAs

(Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011, 2013, 2016, 2017)

Executive Summary of Policy Contained in this Paper

Summaries will lack rationale and background information and may lose nuance of policy. You are highly encouraged to read the entire paper.

- AAPA believes inclusion of PAs in state law and delegation of authority to regulate their practice to a state agency serves to both protect the public from incompetent performance by unqualified medical providers and to define the role of PAs in the healthcare system.
- AAPA, while recognizing the differences in political and healthcare climates in each state, endorses standardization of PA regulation to enhance appropriate and flexible professional practice.

Introduction

Recognition of PAs as medical providers led to the development of state laws and regulations to govern their practice. Inclusion of PAs in state law and delegation of authority to regulate their practice to a state regulatory body serves two main purposes: (1) to protect the public from incompetent performance by unqualified medical providers, and (2) to define the role of PAs in the healthcare system. Since the inception of the profession, dramatic changes have occurred in the way states have dealt with PA practice. In concert with these developments has been the creation of a body of knowledge on legislative and regulatory control of PA practice. It is now possible to state which specific concepts in PA statutes and regulations enable appropriate practice by PAs as medical providers while protecting the public health and safety.

What follows are general guidelines on state governmental control of PA practice. The AAPA recognizes that the uniqueness of each state's political and healthcare climate will require modification of some provisions. However, standardization of PA regulation will enhance appropriate and flexible PA practice nationwide. This document does not contain specific language for direct incorporation into statutes or regulations, nor is it inclusive of all concepts generally contained in state practice acts or regulations. Rather, its intent is to clarify key elements of regulation and to assist states as they pursue improvements in state governmental control of PAs. To see how these concepts can be adapted into legislative language, please consult the AAPA's model state legislation for PAs.

Definition of PA

The legal definition of PA should mean a healthcare professional who meets the qualifications for licensure and is licensed to practice medicine~~.~~ IN COLLABORATION WITH PHYSICIANS.

Qualifications for Licensure

Qualifications for licensure should include graduation from an accredited PA program and passage of the PA National Certifying Examination (PANCE) administered by the National Commission on Certification of PAs (NCCPA).

PA programs were originally accredited by the American Medical Association's Council on Medical Education (1972-1976), which turned over its responsibilities to the AMA's Committee on Allied Health Education and Accreditation (CAHEA) in 1976. CAHEA was replaced in 1994 by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). On January 1, 2001, the Accreditation Review Commission on Education for the PA (ARC-PA), which had been part of both the CAHEA and CAAHEP systems, became a freestanding accrediting body and the only national accrediting agency for PA programs.

Because the law must recognize the eligibility for licensure of PAs that graduated from a PA program accredited by the earlier agencies, the law should specify individuals who have graduated from a PA program accredited by the ARC-PA or one of its predecessor agencies, CAHEA or CAAHEP.

The qualifications should specifically include passage of the national certifying examination administered by the NCCPA**.** No other certifying body or examination should be considered equivalent to the NCCPA or the PANCE**.**

The NCCPA, since 1986, has allowed only graduates of accredited PA programs to take its examination. However, between 1973-1986, the exam was open to individuals who had practiced as PAs in primary care for four of the previous five years, as documented by their supervising physician. Nurse practitioners and graduates of unaccredited PA programs were also eligible for the exam. An exceptions clause should be included to allow these individuals to be eligible for licensure.

Licensure

When a regulatory ~~board~~ AGENCY has verified a PA's qualifications, it should issue a license to the applicant. Although, in the past, registration and certification have been used as the regulatory term for PAs, licensure is now the designation and system used in all states. This is appropriate because licensure is the most stringent form of regulation. Practice without a license is subject to severe penalties. Licensure both protects the public from unqualified providers and utilizes a regulatory term that is easily understood by healthcare consumers.

Applicants who meet the qualifications for licensure should be issued a license. States should not require employment or identification of a supervising, collaborating, or other specific relationship with a physician(s) as a condition or component of licensure. A category of inactive licensure should be available for PAs who are not currently in active practice in the state. If issuance of a full license requires approval at a scheduled meeting of the regulatory agency, a temporary license should be available to applicants who meet all licensure requirements but are awaiting the next meeting of the board.

If the ~~board~~ REGULATORY AGENCY uses continuous clinical practice as a requirement for licensure, it should recognize the nature of PA practice when determining requirements for PAs who are reentering clinical practice (defined as a return to clinical practice as a PA following an extended period of clinical inactivity unrelated to disciplinary action or impairment issues). Each PA reentering clinical practice will have unique circumstances. Therefore, the board should be authorized

to customize requirements imposed on PAs reentering clinical practice. Acceptable options could include requiring current certification, development of a personalized re-entry plan, or temporary authorization to practice for a specified period**.** Although it has not yet been determined conclusively that absence from clinical practice is associated with a decrease in competence, there is concern that this may be the case. Reentry requirements should not be imposed for an absence from clinical practice that is less than two years in duration.

Because of the high level of responsibility of PAs, it is reasonable for licensing agencies to conduct criminal background checks on individuals who apply for licensure as PAs. ~~Licensing~~ REGULATORY agencies should have the discretion to grant or deny licensure based on the findings of background checks and information provided by applicants.

Optimal Team Practice

Since the inception of the profession, PAs have embraced team-based patient-centered practice and continue to do so. Because both PAs and physicians are trained in the medical model and use similar clinical reasoning, PA/physician teams are especially effective and valued.

Optimal team practice ~~occurs when~~ IS DEFINED AS PAs, AS PART OF A HEALTHCARE TEAM, ~~have the ability to collaborate~~ COLLABORATING AND ~~consult~~ CONSULTING WITH physicianS or other qualified medical professionals, as indicated by the patient's condition and the standard of care, and in accordance with the PA's training, experience, and current competencies.

The evolving medical practice environment requires flexibility in the composition of teams and the roles of team members to meet the diverse needs of patients. Therefore, the manner in which PAs and physicians ~~work~~ PRACTICE together ~~should be~~ IS determined at the practice level.

The PA/physician team model continues to be relevant, applicable and patient-centered. ~~the degree of collaboration of the practicing PA~~ THE DETAILS OF THE PRACTICE RELATIONSHIP BETWEEN A PHYSICIAN AND A PA should be determined at the practice level in accordance with the practice type and the experience and competencies of the ~~practicing~~ PA. State law should not ~~require a specific relationship between a PA, and physician, or any other entity~~ MANDATE SPECIFIC DETAILS OF THE PRACTICE OF THE PA in order for a PA to practice to the full extent of their education, training and experience. ~~Such requirements diminish~~ ALLOWING SITE-SPECIFIC FLEXIBILITY PROMOTES TEAM PRACTICE, INCREASES PATIENT ACCESS TO CARE, AND IMPROVES PATIENT SAFETY. ~~and therefore limit patient access to care, without improving patient safety. In addition, such requirements put all providers involved at risk of disciplinary action for reasons unrelated to patient care or outcomes. Like every clinical provider,~~ PAs are responsible for the care they provide. Nothing in the law should require or imply that a physician is responsible or liable for care provided by a PA, unless the PA is acting on the specific instructions of the physician.

Optimal team practice is applicable to all PAs, regardless of specialty or experience.

Whether a PA is early career, changing specialty or simply encountering a condition with which they are unfamiliar, the PA is responsible for seeking consultation as necessary to assure that the patient's treatment is consistent with the standard of care.

Notwithstanding the above provisions, these guidelines recognize that medicine is rapidly changing. A modified model may be better for some states and they should therefore feel free to craft alternative provisions.

PA Practice Ownership and Employment

In the early days of the profession the PA was commonly the employee of the physician. In current systems physicians and PAs may be employees of the same hospital, health system, or large practice. In some situations, the PA may be part or sole owner of a practice. PA practice owners may be the employers of physicians.

To allow for flexibility and creativity in tailoring healthcare systems that meet the needs of specific patient populations, a variety of practice ownership and employer-employee relationships should be available to physicians and to PAs. The PA-physician relationship is built on trust, respect, and appreciation of the unique role of each team member. No licensee should allow an employment arrangement to interfere with sound clinical judgment or to diminish or influence his/her ethical obligations to patients. State law provisions should authorize the regulatory authority to discipline a physician or a PA who allows employment arrangements to exert undue influence on sound clinical judgment or on their professional role and patient obligations.

Disasters, Emergency Field Response and Volunteering

PAs should be allowed to provide medical care in disaster and emergency situations.

This may require the state to adopt language that permits PAs to respond to medical emergencies that occur outside the place of employment. This exemption should extend to PAs who are licensed in other states or who are federal employees. PAs should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.

PAs who are volunteering without compensation or remuneration should be permitted to provide medical care as indicated by the patient's condition and the standard of care, and in accordance with the PA's education, training, and experience. State law should not require a specific relationship between a PA physician, or any other entity for a PA to volunteer.

Scope of Practice

State law should permit PA practice in all specialties and settings. In general, PAs should be permitted to provide any ~~legal~~ medical service that is within the PA's education, training and experience. Medical services provided by PAs may include but are not limited to ordering, performing and interpreting diagnostic studies, ordering and performing therapeutic procedures, formulating diagnoses, providing patient education on health promotion and disease prevention, providing treatment and prescribing medical orders for treatment. This includes the ordering, prescribing, dispensing, administration and procurement of drugs and medical devices. PA education includes extensive training in pharmacology and clinical pharmacotherapeutics.

Additional training, education or testing should not be required as a prerequisite to PA prescriptive authority. PAs who are prescribers of controlled medications should register with the Federal Drug Enforcement Administration.

Dispensing is also appropriate for PAs. The purpose of dispensing is not to replace pharmacy services, but rather to increase patient ability to receive needed medication when access to pharmacy services is limited. Pharmaceutical samples

should be available to PAs just as they are to physicians for the management of clinical problems.

State laws, regulations, and policies should allow PAs to sign any forms that require a physician signature.

Title and Practice Protection

The ability to utilize the title of "PA" or "asociado médico" when the professional title is translated into Spanish should be limited to those who are authorized to practice by their state as a PA. The title may also be utilized by those who are exempted from state licensure but who are credentialed as a PA by a federal employer and by those who meet all the qualifications for licensure in the state but are not currently licensed. A person who is not authorized to practice as a PA should not engage in PA practice unless similarly credentialed by a federal employer. The state should have the clear authority to impose penalties on individuals who violate these provisions.

Regulatory Agencies

Each state must define the regulatory agency responsible for implementation of the law governing PAs. Although a variety of state agencies can be charged with this task, the preferable regulatory structure is a separate PA licensing board comprised of a majority of PAs, with other members who are knowledgeable about PA education, certification, and practice. Consideration should be given to including members who are representative of a broad spectrum of healthcare settings — primary care, specialty care, institutional and rural based practices.

If regulation is administered by a multidisciplinary healing arts or medical board, it is strongly recommended that PAs and physicians who practice with PAs be full voting members of the board.

Any state regulatory agency charged with PA licensure should be sensitive to the manner in which it makes information available to the public. Consumers should be able to obtain information on health professionals from the licensing agency, but the agency must assure that information released does not create a risk of targeted harassment for the PA licensee or their family.

Although there is no conclusive evidence that malpractice claims history correlates with professional competence, many state regulatory agencies are required by statute to make malpractice history on licensees available to the public. If mandated to do so, the board should create a balance between the public's right to relevant information about licensees and the risk of diminishing access to subspecialty care. Because of the inherent risk of adverse outcomes, medical professionals who care for patients with high- risk medical conditions are at greater risk for malpractice claims. The board should take great care in assuring that patient access to this specialized care is not hindered as a result of posting information that could be misleading to the public.

Licensee profiles should contain only information that is useful to consumers in making decisions about their healthcare professional. Healthcare professional profile data should be presented in a format that is easy to understand and supported by contextual information to aid consumers in evaluating its significance.

Discipline

AAPA endorses the authority of designated state regulatory agencies, in accordance with due process, to discipline PAs who have committed acts in violation of state law.

Disciplinary actions may include, but are not limited to, suspension or revocation of a license or approval to practice. In general, the basic offenses are similar for all health professions and the language used to specify violations and disciplinary measures to be used for PAs should be similar to that used for physicians. The law should authorize the regulatory agency to impose a wide range of disciplinary actions so that the board is not motivated to ignore a relatively minor infraction due to inadequate disciplinary choices. Programs and special provisions for treatment and rehabilitation of impaired PAs should be similar to those available for physicians. The Academy also endorses the sharing of information among state regulatory agencies regarding the disposition of adjudicated actions against PAs.

Inclusion of PAs in Relevant Statutes and Regulations

In addition to laws and regulations that specifically regulate PA practice, PAs should be included in other relevant areas of law. This should include, but not be limited to, laws that grant patient-provider immunity from testifying about confidential information; mandates to report child and elder abuse and certain types of injuries, such as wounds from firearms; provisions allowing the formation of professional corporations by related healthcare professionals; and mandates that promote health wellness and practice standards. Laws that govern specific medical technology should authorize those appropriately trained PAs to use them.

For all programs, states should include PAs in the definition of primary care provider when the PA is practicing in the medical specialties that define a physician as a primary care provider.

It is in the best interest of patients, payers and providers that PA-provided services are measured and attributed to PAs; therefore, state law should ensure that PAs who render services to patients be identified as the rendering provider through the claims process and be eligible to be reimbursed directly by public and private insurance.

2018-B-16 – Adopted as Amended

AAPA supports PAs as vital members of the healthcare team in the treatment of ~~Opiate~~ OPIOID Use Disorder. AAPA further supports **PAs HAVING THE SAME BUPRENORPHINE SPECIFIC EDUCATIONAL REQUIREMENTS AND PATIENT CAPITATION LIMITS AS PHYSICIANS WHEN TREATING OPIOID USE DISORDER**. ~~PAs being able to prescribe buprenorphine for the treatment of OUD and~~ **SUPPORTS EQUAL EDUCATION REQUIREMENTS AND PATIENT CAPITATION** ~~opposes having different educational or patient capitation requirements~~ **FOR PAS AND** ~~than~~ **physicians**~~.~~

2018-B-17 – Adopted on Consent Agenda

AAPA endorses establishment of supervised injection facilities in order to decrease the adverse health, social and economic consequences of the ingestion of illicit drugs, and supports the amendment of all pertinent federal, state and local laws necessary to allow the establishment of supervised injection facilities.

AAPA also encourages state constituent organizations to advocate for the establishment of supervised injection facilities.

2018-B-18 – Referred (to be referred by the Speaker to the appropriate body and reported back to the 2019 HOD)

AAPA supports standards to require that PA training programs provide at least 80-percent of didactic instruction as in-person or live lectures.

2018-C-01 (Referred 2017-C-11) – Adopted as Amended

Amend by substitution policy HP-3500.2.1 as follows:

AAPA ENDORSES THE NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS (NCCPA) CERTIFICATION EXAM AS THE ONLY ENTRANCE STANDARD FOR PAS.

2018-C-02 – Adopted on Consent Agenda

Amend policy HP-3200.2.4 as follows:

AAPA ADOPTS ~~endorses the policies of~~ the Accreditation Council FOR ~~on~~ Continuing Medical Education (ACCME) STANDARDS FOR COMMERCIAL SUPPORT AND ITS ASSOCIATED INTERPRETIVE POLICIES AS PART OF ITS OWN ACCREDITATION SYSTEM. ~~on commercial support of continuing medical education (CME) and applies those standards to its own review process.~~

2018-C-03 – Adopted as Amended

Amend by substitution policy HX-4600.1.8 entitled "Comprehensive Health Care Reform", with the policy paper entitled "Promoting the Delivery of Healthcare Services"**.**

Promoting the Access, Coverage and Delivery of Healthcare Services

Executive Summary of Policy Contained in this Paper

Summaries will lack rationale and background information and may lose nuance of policy. You are highly encouraged to read the entire paper.

- AAPA believes the primary goal of our healthcare system is to ensure that everyone in America has access to quality, affordable healthcare.
- AAPA opposes policies that discriminate against patients on the basis of pre-existing conditions, health status, race, ~~gender~~ SEX, age, socio-economic status or other discriminatory demographic or geographic factors.
- AAPA supports a healthcare system that provides essential health services to all patients.

- AAPA supports confronting resource and care limitations while encouraging the use of evidence-based medicine and comparative-effectiveness research.
- AAPA supports policies that optimize the utilization of primary care in our healthcare system.
- AAPA supports policies that promote coordinated, patient-focused care that improves quality and outcomes for patients and their families.
- AAPA supports placing emphasis on health and wellness promotion and disease prevention.
- AAPA supports patient choice of qualified providers, including PAs.
- AAPA recognizes that reform may include changes to the medical liability insurance system and are supportive of policies that enhance transparency and trust between providers and patients.
- AAPA is governed by these principles and is not an advocate for any specific approach to restructuring or financing of the healthcare system.

AAPA encourages policy makers to pursue policies that improve the American healthcare system and ensure everyone in America has access to high-quality, affordable healthcare. AAPA supports policies that prioritize meeting patient needs through evidence-based medicine and that embrace AAPA's guiding principles.

AAPA's guiding principles promote policies that protect patients from discrimination based on pre-existing conditions, health status, race, ~~gender~~ SEX, socio-economic or other discriminatory demographic or health-related factors. The principles also call for access to affordable high-quality healthcare coverage that provides meaningful and robust coverage for all patients. As healthcare providers, PAs believe all patients must have access to a range of essential health services such as maternity care, emergency services, prescription drugs, and treatment for substance abuse and mental health needs. Patients should be satisfied with the type and quality of care being provided. Also, patients should be able to choose a qualified provider that is the best fit for their needs without facing restrictions in obtaining their medical care.

In partnership with our patients and the broader healthcare community, AAPA believes PAs and all healthcare providers should be held to the highest professional standards of evidence-based care and medical ethics.

AAPA and the PA profession are committed to working with the federal government, states, territories, tribes, patients, and all stakeholders to improve the United States' healthcare system. AAPA sets forth the following principles to direct its efforts.

Principles

- AAPA believes the primary goal of our healthcare system is to ensure that everyone in America has access to quality, affordable healthcare.
- AAPA opposes policies that discriminate against patients on the basis of pre-existing conditions, health status, race, ~~gender~~ SEX, age, socio-economic status or other discriminatory demographic or geographic factors.
- AAPA supports a healthcare system that provides essential health

services to all patients.

- AAPA supports confronting resource and care limitations while encouraging the use of evidence-based medicine and comparative-effectiveness research.
- AAPA supports policies that optimize the utilization of primary care in our healthcare system.
- AAPA supports policies that promote coordinated, patient-focused care that improves quality and outcomes for patients and their families.
- AAPA supports placing emphasis on health and wellness promotion and disease prevention.
- AAPA supports patient choice of qualified providers, including PAs.
- AAPA recognizes that reform may include changes to the medical liability insurance system and are supportive of policies that enhance transparency and trust between providers and patients.
- AAPA is governed by these principles and is not an advocate for any specific approach to restructuring or financing of the healthcare system.

Conclusion

AAPA believes policies adopted at the state or federal level should protect coverage for patients, assure access to care provided by PAs and other providers, as well as maintain coverage of essential health benefits for our patients. Patients should have access to a variety of health services and be satisfied with the type and quality of care available. Patients should not experience restrictions due to pre-existing conditions or face other arbitrary condition-based exclusions. We believe following these principles will ensure access to high quality healthcare and improve the quality and transparency of the care available to all Americans.

~~Comprehensive Health Care Reform~~

~~(Adopted 2005, amended 2010, 2013)~~

~~The American health care system requires coordinated and systematic reform in order to meet the needs of the population, ensure quality, and control costs.~~

~~AAPA is not an advocate for any specific structure of health care reform and financing. The guiding principles must include access for all patients; evidence based care; equitable distribution of care and resources; and a payment mechanism that is portable and sustainable for individuals, families, and society.~~

~~Patients should retain a choice of providers, have access to a variety of health services, and should be satisfied with the type and quality of care offered by the providers and the health care system without restrictions due to pre-existing and other arbitrary condition-based exclusions. All providers, allopathic, osteopathic, and alternative, should be held to the highest professional standards of evidence-based care and medical ethics.~~

~~AAPA and the PA profession are committed to working with federal and state legislatures and all involved parties to plan and implement a fair and comprehensive reform of the United States health care system.~~

~~AAPA sets forth the following principles to direct its efforts on health care reform.~~

~~AAPA believes the primary goal of comprehensive health care system reform is to ensure access to quality, affordable, and cost efficient health care for all patients.~~

~~AAPA supports a health care system that will provide basic services to all patients.~~

~~AAPA supports health care that is delivered by qualified providers in physician-directed teams.~~

~~AAPA supports reform that confronts the limits of care and resources and encourages the use of evidence-based medicine and the utilization of comparative-effectiveness information.~~

~~AAPA supports the optimal utilization of primary care in a reformed health system.~~

~~AAPA supports an emphasis on health promotion and disease prevention in health care reform.~~

~~AAPA believes that fair and comprehensive reform of the medical liability insurance system is needed and encourages health care professionals to apologize for adverse outcomes without increasing risk.~~

~~AAPA endorses system reform that enhances the relationship between the patient and the clinician.~~

~~Additionally, AAPA believes that a long range solution to the Medicare physician payment system must be part of health care reform.~~

2018-C-04 – Adopted as Amended

Amend policy HP-3200.5.3 as follows:

AAPA believes it is sound public policy to strengthen the U.S. health care workforce by providing federal and state government support for PA education. Such support includes expanded student loans and scholarships including National Health Service Corps scholarships and loan repayment programs; ~~QUALIFIED~~ ~~**CLINICAL**~~ POSTGRADUATE PROGRAMS; and federal grants and faculty development initiatives; and other forms of assistance including research. Grants to PA programs should include investments to expand high quality clinical education sites where PA students can train and function with interprofessional teams. Government funding for PA education to maintain and expand PA education and faculty training, ALONG WITH OPTIONAL ~~QUALIFIED~~ ~~**CLINICAL**~~ POSTGRADUATE PROGRAMS, will help assure the highest level of health care delivery in the United States. Government funding for research on best practices in education will ensure that effective educational outcomes will lead to high quality, safe health care delivery.

WHILE AAPA MAINTAINS ITS BELIEF THAT ADEQUATE KNOWLEDGE IS OBTAINED THROUGH PA EDUCATION FOR PROFESSIONAL PRACTICE, PAS HAVE THE OPPORTUNITY TO INCREASE THEIR KNOWLEDGE THROUGH OPTIONAL ~~**CLINICAL**~~ POSTGRADUATE TRAINING PROGRAMS. ELIGIBLE PA POSTGRADUATE TRAINING PROGRAMS SHOULD QUALIFY FOR ANY FEDERAL OR STATE FUNDING AVAILABLE TO OTHER ELIGIBLE NON-PHYSICIAN POSTGRADUATE TRAINING PROGRAMS.

2018-C-05 – Adopted on Consent Agenda

Amend by substitution policy HP-3300.1.11.1 as follows:

~~AAPA encourages PAs to become educated about the prevention and management of being overweight and obese for both adult and pediatric populations, and to take an active leadership role in educating their patients and the public about the health risks of being overweight and obese. PAs are encouraged to address the issues of healthy weight and regular physical activity as critical components of health promotion/health maintenance for adults and children in their care. Additionally, PAs are encouraged to be proficient in identifying and treating obesity-related disease states and comorbidities. PAs themselves are encouraged to maintain a healthy weight in order to set the best example for their patients.~~

~~AAPA encourages the PA profession to combat the epidemic of childhood obesity within their clinical practices and to collaborate with public health organizations and federal agencies to meet the goals of improved nutritional education in schools, expanded physical education and exercise programs, and healthier eating habits in the home.~~ ~~*[Adopted 2014]*~~

AAPA ENCOURAGES PAS TO BECOME EDUCATED ABOUT THE PREVENTION AND TREATMENT OF OVERWEIGHT AND OBESITY FOR BOTH THE ADULT AND PEDIATRIC POPULATION. AAPA ENCOURAGES PAS TO TAKE AN ACTIVE LEADERSHIP ROLE IN EDUCATING THEIR PATIENTS AND THE PUBLIC ABOUT THE CHRONIC AND MULTI-FACTORIAL NATURE OF THE DISEASE OF OBESITY, WHICH INCLUDES GENETIC FACTORS, INFECTIONS, HYPOTHALAMIC INJURY, WEIGHT PROMOTING MEDICATIONS, WEIGHT PROMOTING MEDICAL CONDITIONS, NUTRITIONAL IMBALANCE, AND/OR ENVIRONMENTAL FACTORS.

PAS ARE ENCOURAGED TO UNDERSTAND ADIPOSOPATHY AND HOW THIS CONTRIBUTES TO METABOLIC DISEASE PAS ARE ENCOURAGED TO UNDERSTAND HOW PHYSICAL FORCES FROM EXCESS BODY FAT CONTRIBUTE TO BIOMECHANICAL HEALTH CONSEQUENCES OF OBESITY. AAPA ALSO ENCOURAGES PAS TO BECOME EDUCATED ON OBESITY STIGMA AND WEIGHT BIAS, AND HOW THIS CAN IMPACT PATIENT CARE AND A PATIENT'S HEALTH. AAPA ENCOURAGES PAS TO USE PERSON-FIRST LANGUAGE AND NON-STIGMATIZING OBESITY TERMINOLOGY, AS WELL AS TO PROVIDE AN OFFICE ENVIRONMENT WHICH COMFORTABLY ACCOMMODATES PATIENTS WITH OBESITY.

AAPA ENCOURAGES PAS TO BE EDUCATED ON THE APPROPRIATE DIAGNOSIS AND ASSESSMENT OF A PATIENT WITH OVERWEIGHT OR OBESITY, AS WELL AS ON HOW TO FORMULATE A COMPREHENSIVE TREATMENT PLAN, INCLUDING NUTRITION, PHYSICAL ACTIVITY, BEHAVIOR MODIFICATION, AND, IF MEDICALLY APPROPRIATE, PHARMACOLOGY, AND BARIATRIC SURGERY/ ENDOSCOPIC PROCEDURES. PAS ARE ENCOURAGED TO HAVE REFERRAL SOURCES AVAILABLE FOR PATIENTS WITH OVERWEIGHT AND OBESITY WHEN APPROPRIATE, AND REFER TO OBESITY MEDICINE SPECIALISTS AND/ OR BARIATRIC

PROGRAMS, EXERCISE PHYSIOLOGISTS, DIETITIANS, SLEEP SPECIALISTS, PSYCHOLOGISTS, OR OTHER REFERRAL SOURCES, WHEN NEEDED.

2018-C-06 – Adopted

Amend by substitution policies HP-3300.1.8.1 and HP-3300.1.8.2 as follows:

~~HP-3300.1.8.1~~
~~PAs knowledgeable in the area of organ and tissue transplantation should become actively involved with educating the public and other health professionals.~~
~~[Adopted 1985, reaffirmed 1990, 1995, 2000, 2010, amended 2005, 2015]~~

~~HP-3300.1.8.2~~
~~AAPA encourages PAs to be familiar with criteria for identifying potential organ/tissue donors and to be involved where appropriate in the "request" for donation and subsequent acquisition of organ/tissue donation as is medically indicated.~~
~~[Adopted 1988, reaffirmed 1993, 1998, 2003, 2008, 2013]~~

AAPA ENCOURAGES PAS TO BE FAMILIAR WITH THE CRITERIA FOR IDENTIFYING POTENTIAL ORGAN/TISSUE DONORS AND SUPPORTS MULTI-ORGAN AND TISSUE DONATION. PAS SHOULD BE INVOLVED WHERE APPROPRIATE IN THE DISCUSSION REGARDING DONATION AND SUBSEQUENT ACQUISITION OF ORGAN/TISSUE DONATION AS IS MEDICALLY INDICATED. FURTHERMORE, PAS WHO ARE KNOWLEDGEABLE IN THE AREA OF ORGAN AND TISSUE DONATION AND TRANSPLANTATION SHOULD BE ACTIVELY INVOLVED IN EDUCATION OF THOSE IN HEALTHCARE AS WELL AS THE GENERAL PUBLIC.

2018-C-07 – Adopted on Consent Agenda

Amend by substitution policies HX-4200.5.1 and HX-4200.5.2 as follows:

~~HX-4200.5.1 AAPA supports multi-organ and tissue donation.~~
~~[Adopted 1985, amended 2005, reaffirmed 1990, 1995, 2000, 2010, 2015]~~

~~HX-4200.5.2 AAPA support the concept that organs and tissue for transplantation should be made available based on need, rather than ability to pay.~~
~~[Adopted 1986, amended 2006, reaffirmed 1991, 1996, 2001, 2011, 2016]~~

AAPA SUPPORTS ORGAN AND TISSUE DONATION AND NOTES THAT TRANSPLANTATION SHOULD BE MADE AVAILABLE BASED ON NEED RATHER THAN ABILITY TO PAY.

2018-C-08 – Adopted as Amended

Amend policy HX-4100.1.10 as follows:

~~AAPA respects the racial, ethnic, and cultural, diversity of all people. The Academy's~~ AAPA IS COMMITTED TO RESPECTING THE VALUES AND DIVERSITY OF ALL INDIVIDUALS IRRESPECTIVE OF RACE, ETHNICITY, CULTURE, FAITH, ~~GENDER~~ **SEX**, GENDER IDENTITY OR EXPRESSION AND SEXUAL ORIENTATION. ~~commitment to diversity values all individuals.~~ When differences between people are respected everyone benefits. Embracing diversity celebrates the rich heritage of all communities and promotes understanding and respect for the differences among all people.

2018-C-09 – Adopted as Amended

AAPA believes consumer-ordered testing, including, but not limited to, genetic testing, should **HAVE RESULTS AND POTENTIAL CLINICAL IMPLICATIONS INTERPRETED** ~~**be DONE** conducted under the guidance of and~~ in collaboration with a qualified healthcare provider and/or genetic counselor.

2018-C-10 – Adopted on Consent Agenda

Amend policy HX-4100.1.8 as follows:

AAPA endorses the ~~1975~~ World Medical Association Declaration of Tokyo which provides guidelines ~~for physicians and, by nature of their dependent relationship, for PAs, in cases of~~ CONCERNING torture or other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

2018-C-11 – Adopted on Consent Agenda

AAPA supports the use of Patient Drug Monitoring Programs (PDMP) for the prescribing and dispensing of controlled substances at the state level.

AAPA supports the ability of prescribers and dispensers to query other states for similar information.

2018-C-12 – Adopted on Consent Agenda

AAPA believes that palliative medicine is a core component of PA practice and encourages all PAs to acquire training in this discipline commensurate with their clinical practice.

And, be it further resolved,

AAPA supports inclusion of PAs in any proposed educational funding for health care providers in hospice and palliative medicine.

And, be it further resolved that,

AAPA believes in partnering with other relevant associations including the PAEA, Patient Quality of Life Coalition (PQLC), American Academy of Hospice and Palliative Medicine (AAHPM), and ARC-PA to advance the progress of palliative care education.

2018-C-13 – Adopted as Amended

AAPA supports initiatives for increased funding for development and operation OF PA PROGRAMS AT ~~for~~ Historically Black Colleges and Universities, ~~(HBCU), and~~ PREDOMINANTLY BLACK INSTITUTIONS, Hispanic-Serving Institutions ~~(HSI)~~, AND RURAL SERVING INSTITUTIONS.

2018-C-14 – Adopted

AAPA supports initiatives for increased federal loan limits to provide parity with loan limits available to other health care professional students.

2018-C-15 – Adopted on Consent Agenda

AAPA supports the removal of federal restrictions on the study of gun violence by the CDC.

2018-C-16 – Referred (to be referred by the Speaker to the appropriate body and reported back to the 2019 HOD)

Adopt the policy paper entitled "Restriction of the Use of Opioid Containing Medications in Children".

Restriction of the Use of Opioid Containing Medications in Children

Executive Summary of Policy Contained in this Paper

Summaries will lack rationale and background information, and may lose nuance of policy. You are highly encouraged to read the entire paper.

- AAPA supports regulations and legislation that restrict the use of opioid containing medications in children.
- AAPA supports the Food and Drug Administration's efforts to curtail the prescribing of opioid containing medications to children by healthcare providers.
- PAs should be aware of the dangers of the use of codeine and hydrocodone in children, and should limit their use as treatments for cough suppression, and of codeine for pain.

In 2016 the FDA examined the use of opioid medications in response to the opioid abuse epidemic. Codeine products and hydrocodone including opioid-containing antitussive (OCA) products and pain medications came under scrutiny with their use in children. As codeine is a prodrug that must be metabolized in the liver, the response to the medication is unpredictable and varies from no effect to high sensitivity.[1] Potential

adverse side effects from codeine are respiratory depression and death, particularly in children under the age of 12 years.[2]

It has been well established that there is limited evidence that cough suppression in children is necessary or beneficial, and that the medications available have little efficacy.[1,3,4] It has also been reported that the use of codeine for pain post-operatively for adenotonsillectomy for obstructive sleep apnea (OSA) carried a higher risk for death.[2] Therefore in April 2017 the FDA issued a contraindication to using codeine to treat pain or cough in children under the age of 12 years, and a warning about using it in children aged 12 – 18 years who are obese or who have OSA or severe lung disease. In January, 2018 the FDA went a step further in stripping both codeine and hydrocodone of the indication for the treatment of cough in children younger than the age of 18 years, and codeine for treatment of pain.

With the United States currently battling an opioid abuse epidemic, PAs need to be aware of these new recommendations and put them into practice. PAs further need to provide information to families about the FDAs stance on the use of OCA products, and of codeine for pain. PAs would benefit from educational opportunities covering more effective treatment modalities for cough and pain management.

Conclusion

AAPA supports regulations and legislation that restricts the use of codeine and hydrocodone in children under the age of 18 years. AAPA stands in support of the FDA's new recommendations for the restriction of the use of opioid containing medications for the treatment of cough and pain in children. AAPA encourages all PAs to be aware of the dangers of these medications in children. AAPA further encourages all PAs to keep prescribing practices in line with evidence based medicine and the recommendations of the FDA.

References

1. Gardiner, S, Chang, A, Marchant, J, Petsky, H. Codeine versus placebo for chronic cough in children. *Cochrane Database of Systematic Reviews* 2016, Issue 7.
2. Tobias, JD, Green TP, Cote, CJ. Codeine : Time to Say "No". *Pediatrics*. 2016;138(4):e1-e6.
3. Carr, BC. Efficacy, abuse, and toxicity of over-the-counter cough and cold medicines in the pediatric population. *Current Opinion in Pediatrics*. 2006;18:184-188.
4. Food and Drug Administration News Release. FDA acts to protect kids from serious risks of opioid ingredients contained in some prescription cough and cold products by revising labeling to limit pediatric use. https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm592109.htm. January 11, 2018.

2018-C-17 – Adopted on Consent Agenda

Amend policy HX-4400.1.1 as follows:

AAPA believes that PAs should be familiar with social and cognitive skills that foster non-violent conflict resolution. In addition, PAs should support the incorporation of age-appropriate school and community-based curricula that recognize racial, ethnic,

SEXUAL AND GENDER MINORITY, ~~and~~ cultural, AND RELIGIOUS diversity and that teach the skills of non-violent conflict resolution.

2018-C-18 – Adopted

AAPA supports the National Action Alliance for Suicide Prevention's report, "Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe", as a guide for PAs.

And further resolved

The HOD recommends that AAPA develops a communication strategy to inform its members.

And further resolved

The HOD recommends that AAPA communicate this information to PAEA to consider for inclusion in PA program curriculums.

And further resolved

The HOD recommends that AAPA includes this information in future AAPA CME activities.

Resolution of Condolence

2018-COND-01

Resolution of Condolence
John Sallstrom, PA-C
May 2018

Whereas, the North Carolina Academy of PAs suffered a great loss with the untimely passing of John Sallstrom on April 6, 2018, and

Whereas John graduated from the PA Program at the Nebraska College of Medicine in 1975, and

Whereas John served as a PA in the Air Force and retired as a Major, and

Whereas John moved to Morganton, NC in 1988 and worked as a PA at Burke Primary Care providing for medical services for the citizens of Burke County, and

Whereas John served on the Stead Center Task Force which brought the vision to have the North Carolina Academy of PAs have a permanent house in North Carolina, and

Whereas John served as President-elect, President and Past President of the North Carolina Academy of PAs from 2009-2011, and

Whereas John served as Chief Delegate from North Carolina in the AAPA House of Delegates in 2010,

Whereas John served as the President of North Carolina Academy of PAs Endowment from 2004 until 2008, and

Whereas John worked diligently on behalf of the North Carolina Academy of PAs Endowment to further the success of the philanthropic arm of the state's PA professional organization, and

And whereas John's kind, gentle soft-spoken manner served to help move the PA profession forward in North Carolina, be it

Resolved that the House of Delegates of the AAPA recognize John Sallstrom for his many contributions to the PA profession and the care he provided to his many patients, and be it further

Resolved, a copy of this resolution be provided to his family with deepest sympathy from the members of the AAPA.

House Elections 2018	**Results**
Vice President/Speaker	David Jackson
First Vice Speaker	William Reynolds
Second Vice Speaker	Todd Pickard
Nominating Work Group	Peggy Walsh
	Monica Ward