

## 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.

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

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

	<a href="#">Physician Assistants</a>		Amended
2018-B-15	<a href="#">Guidelines for State Regulation of PAs</a>	2432	Rejected
2018-B-16	<a href="#">Opiate Use Disorder</a>	2700	Adopted as Amended
2018-B-17	<a href="#">Support for Supervised Injection Facilities</a>	2711	Adopted on Consent Agenda
2018-B-18	<a href="#">Standards Requiring In-Person Instruction</a>	2721	Referred
2018-C-01	<a href="#">Recognizing New PA Certifying Agencies (Tabled 2017-C-11)</a>	2727	Adopted as Amended
2018-C-02	<a href="#">ACCME Support</a>	2735	Adopted on Consent Agenda
2018-C-03	<a href="#">Promoting the Delivery of Healthcare Services</a>	2745	Adopted as Amended
2018-C-04	<a href="#">Postgraduate Training Program Funding</a>	2878	Adopted as Amended
2018-C-05	<a href="#">Obesity</a>	2904	Adopted on Consent Agenda
2018-C-06	<a href="#">Organ and Tissue Donation (HP Policies)</a>	2957	Adopted
2018-C-07	<a href="#">Organ and Tissue Donation (HX Policies)</a>	2982	Adopted on Consent Agenda
2018-C-08	<a href="#">Human Rights – General</a>	2997	Adopted as Amended
2018-C-09	<a href="#">Consumer-ordered Testing</a>	3010	Adopted as Amended
2018-C-10	<a href="#">World Medical Association Declaration of Tokyo</a>	3017	Adopted on Consent Agenda
2018-C-11	<a href="#">Use of Patient Drug Monitoring Programs</a>	3026	Adopted on Consent Agenda
2018-C-12	<a href="#">Hospice and Palliative Medicine</a>	3034	Adopted on Consent Agenda
2018-C-13	<a href="#">Increasing PA Diversity</a>	3051	Adopted as Amended
2018-C-14	<a href="#">Support for PA Student Federal Loan Limits</a>	3058	Adopted
2018-C-15	<a href="#">Removal of Restrictions on the Study of Gun Violence by the CDC</a>	3063	Adopted on Consent Agenda
2018-C-16	<a href="#">Medications Containing Opioids and Children</a>	3068	Referred
2018-C-17	<a href="#">Diversity and Non-violent Conflict Resolution</a>	3133	Adopted on Consent Agenda
2018-C-18	<a href="#">Support for Decreasing Suicide</a>	3143	Adopted
<b>Reaffirmed Policies</b>			
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	
<b>Expired Policies</b>		
BA-2500.4.2	HX-4500.8	
<b>Resolutions of Condolence</b>	<b>Line Number</b>	<b>Purpose</b>
<a href="#">2018-COND-01</a>	3164	Condolence for John Sallstrom
<b>House Elections</b>	<b>Line Number</b>	
<a href="#">Results</a>	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  
William T. Reynolds, Jr., MPAS, PA-C, DFAAPA  
Todd A. Pickard, MMSc, PA-C, DFAAPA

Speaker  
First Vice Speaker  
Second Vice Speaker

1 **2018-A-01 – Adopted (Requires AAPA Board of Directors Ratification)**

2  
3 Amend AAPA Bylaws Article III, Section 1 as follows:

4  
5 ARTICLE III Membership.

6  
7 Section 1: Eligibility. Membership in this Academy shall be open to all individuals  
8 wishing to participate in promoting the purposes of the Academy. Specifically,  
9 membership shall consist of individuals who are cognizant of their obligation to the  
10 public and who meet the requirements for membership as defined by AAPA’s Articles  
11 of Incorporation, these Bylaws, and such other of AAPA’s rules and policies that may be  
12 established from time to time. Membership in the Academy is an honor that confers  
13 upon the individual certain rights and responsibilities. Adherence to ~~the AAPA~~  
14 ~~Guidelines for Ethical Conduct for the PA Profession (Policy Paper 15 – page 179),~~  
15 AAPA’s Articles of Incorporation, these Bylaws, and AAPA’s rules and policies, and  
16 generally acting in a manner that is consistent with AAPA’s ~~purposes~~ **MISSION**, is a  
17 condition of membership.  
18

19 **2018-A-02 – Adopted (Requires AAPA Board of Directors Ratification)**

20  
21 Amend AAPA Bylaws Article III, Sections 3-10 as follows:

22  
23 ARTICLE III Membership.

24  
25 Section 3: Fellow Members. A fellow member shall be a PA who is a graduate of a  
26 PA program accredited by the Accreditation Review Commission on Education for the  
27 Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on  
28 Allied Health Education and Accreditation [CAHEA], Commission on Accreditation of  
29 Allied Health Education Programs [CAAHEP]) or who has passed the Physician  
30 Assistant National Certifying Examination (PANCE) administered by the National  
31 Commission on Certification of Physician Assistants (NCCPA) or an examination  
32 administered by another agency approved by the Academy. Fellow members must satisfy  
33 such continuing medical and/or medically related educational requirements as may be  
34 prescribed by the Academy. Non-clinical fellow members will not be required to  
35 maintain continuing medical education (CME). Fellow members shall ~~have the~~  
36 ~~privileges of voting and be eligible~~ **BE ENTITLED** to **VOTE AND** hold office.  
37

38 Section 4: Student Members. A student member is an individual who is enrolled in  
39 an ARC-PA or successor agency approved PA program. Except as otherwise provided in  
40 these Bylaws with respect to the election of the Student Director, student members shall  
41 not ~~have the privilege~~ **BE ENTITLED** to vote or hold office. Notwithstanding the  
42 preceding sentence, one student shall be elected by his/her peers to sit on the Board of  
43 Directors and this Student Director shall have ~~and enjoy~~ all rights and privileges of any  
44 other member of such Board.  
45

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

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

50  
51 Section 6: Sustaining Members. Sustaining members shall consist of ARC-PA,  
52 CAHEA, CAAHEP or successor agency approved PA program graduates who have  
53 chosen not to actively practice in the profession and opt to be classified as sustaining  
54 members. Sustaining members shall be entitled to privileges of the floor, but shall not be  
55 entitled to vote or hold office.

56  
57 Section 7: Physician Members. Physician members shall consist of licensed  
58 physicians who desire to associate with the Academy. Physician members shall be  
59 entitled to the privileges of the floor, but shall not be entitled to vote or hold office.

60  
61 Section 8: Associate Members. Associate members shall consist of representatives of  
62 businesses engaged in selling products or services to PAs or individuals employed by  
63 government agencies who do not qualify for any other membership category. Associate  
64 members are SHALL not BE entitled to the privileges of the floor, to vote, or to hold  
65 office.

66  
67 Section 9: Honorary Members. Honorary membership may be conferred by the  
68 Academy upon non-PAs who have rendered distinguished service to the PA profession.  
69 Honorary members shall have all the rights and privileges of the Academy are SHALL  
70 not BE entitled to VOTE OR HOLD OFFICE. of voting, holding office, and/or chairing  
71 commissions or work groups. All honorary members shall be exempt from the payment  
72 of dues.

73  
74 Section 10: Retired Members. A retired member shall be a PA who is a former fellow  
75 member who has chosen to retire from the profession, and opts to be classified as a  
76 retired member. Retired members shall be entitled to privileges of the floor, but shall not  
77 be entitled to vote or hold office.

78  
79 **2018-A-03 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)**

80  
81 Amend AAPA Bylaws Article III, Section 4 as follows:

82  
83 **ARTICLE III Membership.**

84  
85 Section 4: Student Members. A student member is an individual who is enrolled in  
86 an ARC-PA or successor agency approved PA program. Except as otherwise provided in  
87 these Bylaws with respect to the election of the Student Director, student members shall  
88 not have the privilege to vote or hold office. Notwithstanding the preceding sentence,  
89 one student shall be elected by his/her peers to sit on the Board of Directors and this  
90 Student Director shall have and enjoy all rights and privileges of any other member of  
91 such Board.

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93 **2018-A-04 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)**

94  
95 Amend AAPA Bylaws Article V as follows:

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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.



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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 CURRENTLY SERVING. THEY ARE~~



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

198  
199 **2018-A-07 – Adopted as Amended (Requires AAPA Board of Directors Ratification)**

200  
201 Amend AAPA Bylaws Article XIII, Section 3 as follows:

202  
203 Section 3: Eligibility and Qualifications of Candidates for Elected Positions Other  
204 Than Student Director or Nominating Work Group Member.

- 205  
206 a. A candidate must be a fellow member of AAPA.  
207 b. A candidate must be a member of an AAPA Chapter.  
208 c. A candidate must have been an AAPA fellow member and/or student  
209 member for the last three years.  
210 d. A candidate must have accumulated at least three distinct years of  
211 experience in the past five years in at least two of the following major  
212 areas of professional involvement. This experience requirement will be  
213 waived for currently sitting AAPA Board members who choose to run for  
214 a subsequent term of office.  
215 i. An AAPA or constituent organization officer, **OR** board  
216 member,  
217 ii. **AN AAPA** committee, **council**, commission, work group,  
218 task force **MEMBER OR** chair.  
219 iii. A delegate to the AAPA House of Delegates or a  
220 representative to the Student Academy of the AAPA's  
221 Assembly of Representatives.  
222 iv. A board member, **OR** trustee, ~~or committee chair~~ **OR**  
223 **COMMISSIONER** of the Student Academy of the AAPA,  
224 PA Foundation, Physician Assistant History Society,  
225 AAPA Political Action Committee, Physician Assistant  
226 Education Association, ~~or~~ National Commission on  
227 Certification of Physician Assistants, **OR**  
228 **ACCREDITATION REVIEW COMMISSION ON**  
229 **EDUCATION FOR THE PHYSICIAN ASSISTANT.**  
230 v. **POSITION APPOINTED BY THE AAPA PRESIDENT,**  
231 **SPEAKER OF THE HOUSE AND/OR THE** Board  
232 **appointee.**  
233

234 **2018-A-08 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)**

235  
236 Amend AAPA Bylaws Article IX as follows:

237  
238 Article IX Judicial Affairs  
239

240 Section 1: The Board of Directors shall be responsible for the internal judicial affairs  
241 of the Academy.  
242

243 Section 2: The Academy has the inherent right through the Board of Directors to  
244 discipline, suspend, or expel an Academy member or Academy-recognized PA  
245 organization.  
246

247 Section 3: Anyone may in good faith refer charges against any Academy member or  
248 ~~Academy recognized PA organization~~ CONSTITUENT ORGANIZATION believed to  
249 have violated the Academy Articles, Bylaws, policies, or rules, or for unethical or  
250 unprofessional conduct, ~~or for failure to uphold the principles outlined in the Guidelines~~  
251 ~~for Ethical Conduct for the PA Profession (Policy Paper 15 — page 179)~~, or for acting in a  
252 manner inconsistent with AAPA's ~~purposes~~ MISSION.  
253

254 Section 4: The Academy, after due notice and hearing, may discipline any member or  
255 ~~Academy recognized PA organization~~ CONSTITUENT ORGANIZATION for a  
256 violation of the Academy Articles, Bylaws, policies, or rules, or for unethical or  
257 unprofessional conduct, ~~or for failure to uphold the principles outlined in the Guidelines~~  
258 ~~for Ethical Conduct for the PA Profession (Policy Paper 15 — page 179)~~, or for acting in a  
259 manner inconsistent with AAPA's ~~purposes~~ MISSION. The notice and hearing  
260 procedures for such disciplinary actions may be determined by the Board of Directors  
261 from time to time.  
262

263 Section 5: If any member has their PA license or temporary permit currently revoked  
264 as the result of a final adjudicated disciplinary action for violation of their professional  
265 practice statutes or regulations, then their AAPA membership shall be automatically  
266 revoked.  
267

268 Section 6: Any individual who has their PA license or temporary permit currently  
269 revoked as the result of a final adjudicated disciplinary action for violation of their  
270 professional practice statutes or regulations shall be ineligible to apply for AAPA  
271 membership during the period of that revocation.  
272

273 **2018-A-09 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)**  
274

275 Amend AAPA Bylaws Article XIV, Section 5 and 6 as follows:  
276

277 Section 5: Each amendment to be presented at the annual meeting of the House of  
278 Delegates shall be filed with the ~~Judicial Affairs~~ GOVERNANCE Commission at least  
279 three (3) months prior to that meeting. The ~~Judicial Affairs~~ GOVERNANCE  
280 Commission's proposed amendments shall be exempt from the three (3) month filing  
281 requirement.  
282

283 a. To be considered for electronic vote of the House of Delegates, amendments  
284 must be submitted 150 days or greater before the annual meeting of the House of  
285 Delegates.  
286

287 Section 6: Proposals that are not initiated by the Board of Directors will be presented to  
288 the Board of Directors substantially in the form presented to the **Judicial Affairs**  
289 **GOVERNANCE** Commission with such technical changes and conforming amendments  
290 to the proposal or existing Bylaws as the **Judicial Affairs GOVERNANCE** Commission  
291 shall deem necessary or desirable.  
292

293 **2018-A-10 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)**  
294

295 Amend AAPA Bylaws Article III as follows:  
296

297 **ARTICLE III** Membership.  
298

299 Section 4: Student Members. A student member is an individual who is enrolled in  
300 an ARC-PA or successor agency approved PA program. Except as otherwise provided in  
301 these Bylaws with respect to the election of the Student Director, student members shall  
302 not have the privilege to vote or hold office. Notwithstanding the preceding sentence, one  
303 student shall be elected by **his/her peers ELIGIBLE STUDENT MEMBERS** to sit on the  
304 Board of Directors and this Student Director shall have and enjoy all rights and privileges  
305 of any other member of such Board.  
306

307 Section 12: Suspension or Revocation of Membership. Membership in the Academy  
308 may be suspended or revoked as provided in Article IX. Any member who has been  
309 suspended or has their membership revoked shall not be entitled to any of the rights or  
310 benefits of this Academy or be permitted to take part in any of the proceedings until **(s)he**  
311 **THEIR MEMBERSHIP** has been reinstated.  
312

313 **2018-A-11 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)**  
314

315 Amend AAPA Bylaws Articles VI, VIII, and XIII as follows:  
316

317 **ARTICLE VI** House of Delegates.  
318

319 Section 3: House Officers. The House of Delegates shall elect from among its  
320 members the following House Officers: a Speaker (who shall also serve as Vice President  
321 of the Academy), a First Vice Speaker, and a Second Vice Speaker (the First Vice  
322 Speaker and the Second Vice Speaker are not Officers of the Corporation).  
323

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

- 334 ii. The First Vice Speaker shall assume the duties of the Speaker in the event  
335 of the absence of the Speaker, or in the event of vacancy in the position of  
336 Speaker.  
337 iii. The Second Vice Speaker will assume the duties of the First Vice Speaker  
338 in the absence of the First Vice Speaker, or in the event of vacancy in the  
339 position of First Vice Speaker.  
340 iv. The Second Vice Speaker shall be responsible for verification of the  
341 credentials of the delegates, for compiling the records of all general  
342 meetings of the House of Delegates, and for submitting such records to the  
343 Secretary-Treasurer of the Academy for filing with the Academy's books  
344 and records.  
345

346 d. Resignation or Removal of House Officers. Any House Officer may resign at any  
347 time by giving written notice to the Speaker, the President of the Academy, or the Board  
348 of Directors. Such resignation shall take effect at the time specified in such notice, or, if  
349 no time is specified, at the time such resignation is tendered. Any House Officer may be  
350 removed from ~~his or her position~~ OFFICE at any time, with or without cause, by the  
351 affirmative majority vote of the House of Delegates. Removal may only occur at a  
352 meeting called for that purpose, and the meeting notice shall state that the purpose, or one  
353 of the purposes, of the meeting is removal of the House Officer. Vacancies in these  
354 positions shall be filled in accordance with Article VI, Section 3 and Article XIII, Section  
355 10 of these Bylaws.  
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357 ARTICLE VIII Chief Executive Officer.  
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359 The Chief Executive Officer (CEO) is an employee of the Academy. The CEO shall be  
360 bonded at the expense of the Academy in such amounts as the Board of Directors may  
361 require. The CEO shall be a non-voting member of the Board of Directors. The CEO  
362 shall be under the direction and oversight of the Board of Directors and, in the case of  
363 ~~his/her~~ THE CEO'S death, resignation, or removal; the Board of Directors shall have the  
364 power to fill the vacancy.  
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366 ARTICLE XIII Elections.  
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368 Section 10: Vacancies. Academy Officers and Directors, the Student Director and  
369 House Officers may resign or be removed as provided in these Bylaws. The method of  
370 filling positions vacated by the holder prior to completion of term shall be as follows:  
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- 372 a. OFFICE OF THE PRESIDENT. The President-elect shall become the President  
373 to serve the unexpired term. The President-elect shall then serve ~~his/her own A~~  
374 successive term as President.  
375

376 **2018-A-12 – Adopted**  
377

378 Amend policy HP-3700.1.2 entitled “Guidelines Ethical Conduct for the PA Profession”  
379 as follows:  
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381 **Guidelines for Ethical Conduct for the PA Profession**

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

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**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.

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

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

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

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

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

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

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

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

#### 464 **Statement of Values of the PA Profession**

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

- 477
- 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.
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## **The PA and Patient**

### **PA Role and Responsibilities**

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484 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.

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490 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

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496 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.

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506 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.

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### **The PA and Diversity**

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

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### **Nondiscrimination**

514 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.

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### **Initiation and Discontinuation of Care**

520 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

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

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

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

### 535 **Informed Consent**

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

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

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

### 554 **Confidentiality**

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

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

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

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

### 577 **The Patient and the Medical Record**

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

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

### 591 **Disclosure**

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

### 597 **Care of Family Members and Co-workers**

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

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

### 613 **Genetic Testing**

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

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

### 625 **Reproductive Decision Making**

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

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

### 635 **End of Life**

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

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

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

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

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

### 656 **The PA and Individual Professionalism**

#### 657 **Conflict of Interest**

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

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

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

669 **Professional Identity**

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

673 **Competency**

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

679 **Sexual Relationships**

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

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

688 **Gender Discrimination and Sexual Harassment**

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

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

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

703 **The PA and Other Professionals**

704 **Team Practice**

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

709 **Illegal and Unethical Conduct**

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

713 **Impairment**

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

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

### 721 **PA–Physician Relationship**

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

### 726 **Complementary and Alternative Medicine**

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

732 The PA and the Health Care System

### 733 **Workplace Actions**

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

### 740 **PAs as Educators**

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

### 745 **PAs and Research**

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

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

753 In scientific writing, PAs should report information honestly and accurately.

754 Sources of funding for the research must be included in the published reports.

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

### 759 **PAs as Expert Witnesses**

760 The PA expert witness should testify to what he or she believes to be the truth.

761 The PA’s review of medical facts should be thorough, fair, and impartial.

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

766 The PA and Society

767 **Lawfulness**

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

770 **Executions**

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

773 **Access to Care / Resource Allocation**

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

780 **Community Well Being**

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

788 **Conclusion**

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

795  
796 **2018-A-13 – Adopted as Amended**

797  
798 Amend policy HP-3700.1.2 entitled “Guidelines for Ethical Conduct for the PA  
799 Profession”.

800  
801 **Guidelines for Ethical Conduct for the PA Profession**  
802 *(Adopted 2000, amended 2004, 2006, 2007, 2008, reaffirmed 2013)*

803  
804 **Introduction**

805 **Statement of Values of the PA Profession**

806 PA Role and Responsibilities

807 The PA and Diversity

808 Nondiscrimination

809 Initiation and Discontinuation of Care

810 Informed Consent  
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**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.



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## **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 THROUGH 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

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

### 908 **Statement of Values of the PA Profession**

- 909
- 910 ○ PAs hold as their primary responsibility the health, safety, welfare, and dignity
- 911 of all human beings.
- 912 ○ PAs uphold the tenets of patient autonomy, beneficence, nonmaleficence, and
- 913 justice.(1)
- 914 ○ PAs recognize and promote the value of diversity.
- 915 ○ PAs **DO NOT DISCRIMINATE; PAS** treat equally all persons who seek their
- 916 care.
- 917 ○ PAs hold in confidence the **PATIENT-SPECIFIC** information shared in the
- 918 course of practicing medicine.
- 919 ~~○ PAs assess their personal capabilities and limitations, striving always to~~
- 920 ~~improve their medical practice.~~
- 921 ○ PAs actively seek to expand their knowledge and skills, keeping abreast of
- 922 advances in medicine. **PAS ASSESS THEIR PERSONAL CAPABILITIES**
- 923 **AND LIMITATIONS, STRIVING ALWAYS TO IMPROVE THEIR**
- 924 **PRACTICE OF MEDICINE.**
- 925 ○ PAs work with other members of the healthcare team to provide compassionate
- 926 and effective care of patients.
- 927 ○ PAs use their knowledge and experience to contribute to **A HEALTHY**
- 928 **COMMUNITY AND THE IMPROVEMENT OF PUBLIC HEALTH. an**
- 929 ~~improved community.~~
- 930 ○ PAs respect their professional relationship with ~~physicians~~ **ALL MEMBERS**
- 931 **OF THE HEALTHCARE TEAM.**
- 932 ○ PAs share and expand **CLINICAL AND PROFESSIONAL** knowledge within
- 933 **PAS AND PA STUDENTS. the profession.**

### 934 **The PA and Patient**

#### 935 **PA Role and Responsibilities**

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

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

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

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

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

### 966 **The PA and Diversity**

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

### 968 **Nondiscrimination OF PATIENTS AND FAMILIES**

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

974 **SEE ALSO SECTION ON NONDISCRIMINATION IN THE WORKPLACE AND**  
975 **CLASSROOM**

### 976 **Initiation and Discontinuation of Care**

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

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

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

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

997 **MANY REGULATORY BOARDS HAVE RULES OR POSITION**  
998 **STATEMENTS ADDRESSING TERMINATION OF CARE. PAS SHOULD**  
999 **UNDERSTAND ANY REGULATORY REQUIREMENTS BEFORE TAKING**  
1000 **ACTION.**

### 1001 **Informed Consent**

1002 PAs have a duty to protect and foster an individual patient’s free and informed  
1003 choices. The doctrine of informed consent means that a PA provides adequate  
1004 information that is comprehensible to a **competent** patient or patient surrogate **THAT**  
1005 **WHO HAS MEDICAL DECISION-MAKING CAPACITY**. At a minimum, this should  
1006 include the nature of the medical condition, the objectives of the proposed treatment,  
1007 treatment options, possible outcomes, and the risks involved. PAs **should be ARE**  
1008 **EXPECTED TO BE** committed to the concept of shared decision making, which  
1009 involves assisting patients in making decisions that account for medical, situational and  
1010 personal factors.

1011 **SEE ALSO, AAPA POLICY PAPER, USE OF MEDICAL INTERPRETERS FOR**  
1012 **PATIENTS WITH LIMITED ENGLISH PROFICIENCY.**

1013 In caring for adolescents, the PA **should MUST** understand all of the laws and  
1014 regulations in his or her jurisdiction that are related to the ability of minors to consent to  
1015 or refuse healthcare. Adolescents should be encouraged to involve their families in  
1016 healthcare decision making. The PA **should IS EXPECTED TO also** understand  
1017 consent laws pertaining to emancipated or mature minors.

1018 **(See ALSO, the section on Confidentiality AND THE AAPA POLICY PAPER,**  
1019 **ATTEMPTS TO CHANGE A MINOR'S SEXUAL ORIENTATION, GENDER IDENTITY,**  
1020 **OR GENDER EXPRESSION.)**

1021 When the person giving consent is a patient’s surrogate, a family member, or  
1022 other legally authorized representative, the PA should take reasonable care to assure that  
1023 the decisions made are consistent with the patient’s best interests and personal  
1024 preferences, if known. If the PA believes the surrogate’s choices do not reflect the  
1025 patient’s wishes or best interests, the PA should work to resolve the conflict. This may  
1026 require the use of additional resources, such as an ethics committee.

### 1027 **Confidentiality**

1028 PAs should maintain confidentiality. By maintaining confidentiality, PAs respect  
1029 patient privacy and help to prevent discrimination based on medical conditions. If  
1030 patients are confident that their privacy is protected, they are more likely to seek medical  
1031 care and more likely to discuss their problems candidly.

1032 In cases of adolescent patients, family support is important but should be balanced  
1033 with the patient’s need for confidentiality and the PA’s obligation to respect their  
1034 emerging autonomy. Adolescents may not be of age to make independent decisions about  
1035 their health, but providers should respect that they soon will be. To the extent they can,  
1036 PAs should allow these emerging adults to participate as fully as possible in decisions  
1037 about their care. It is important that PAs be familiar with and understand  
1038 **INSTITUTIONAL POLICIES AND LOCAL, STATE AND FEDERAL** ~~the~~ laws and  
1039 regulations, **in their jurisdictions** that relate to the confidentiality rights of adolescent  
1040 patients.

1041 **(See ALSO, the section on Informed Consent.)**

1042 Any communication about a patient conducted in a manner that violates  
1043 confidentiality is unethical. Because written, electronic, and verbal information may be  
1044 intercepted or overheard, the PA should always be aware of anyone who might be  
1045 monitoring communication about a patient.

1046 PAs should **USE AND ADVOCATE FOR choose** methods of storage and  
1047 transmission of patient information that minimize the likelihood of data becoming  
1048 available to unauthorized persons or organizations. Computerized record keeping and  
1049 electronic data transmission present unique challenges that can make the maintenance of

1050 patient confidentiality difficult. PAs should advocate for policies and procedures that  
1051 secure the confidentiality of patient information.

### 1052 **The Patient and the Medical Record**

1053 PAs have an obligation to keep information in the patient’s medical record  
1054 confidential. Information should be released only with the written permission of the  
1055 patient or the patient’s legally authorized representative. Specific exceptions to this  
1056 general rule may exist (e.g., workers compensation, communicable disease, HIV,  
1057 knife/gunshot wounds, abuse, and substance abuse). It is important that a PA be familiar  
1058 with and understand the **INSTITUTIONAL POLICIES AND LOCAL, STATE AND**  
1059 **FEDERAL** laws and regulations ~~in his or her jurisdiction~~ that relate to the release of  
1060 information. For example, stringent legal restrictions on release of genetic test results and  
1061 mental health records often exist.

1062 Both ethically and legally, a patient has certain rights to know the information  
1063 contained in his or her medical record. While the chart is legally the property of the  
1064 practice or the institution, the information in the chart is the property of the patient. Most  
1065 states have laws that provide patients access to their medical records. The PA should  
1066 know the laws and facilitate patient access to the information.

### 1067 **Disclosure OF MEDICAL ERRORS**

1068 **A PATIENT DESERVES COMPLETE AND HONEST EXPLANATIONS OF**  
1069 **MEDICAL ERRORS AND ADVERSE OUTCOMES. A PA should disclose to his or her**  
1070 **supervising physician information about errors made in the course of caring for a patient.**  
1071 The **supervising physician and** PA should disclose the error to the patient if such  
1072 information is significant to the patient’s interests and well-being. Errors do not always  
1073 constitute improper, negligent, or unethical behavior, but failure to disclose them may.

1074 **SEE AAPA POLICY PAPER, ACKNOWLEDGING AND APOLOGIZING FOR**  
1075 **ADVERSE OUTCOMES.**

### 1076 **Care of Family Members and Co-workers**

1077 Treating oneself, co-workers, close friends, family members, or students whom  
1078 the PA supervises or teaches ~~may be~~ **IS CONTEXTUAL (2, 3) AND CASUISTIC**  
1079 **(EXTRACING REASON FROM CASE STUDY)** ~~unethical or create conflicts of~~  
1080 **interest.** For example, it might be ethically acceptable to treat one’s own child for a case  
1081 of otitis media, but it probably is not acceptable to treat one’s spouse for depression. PAs  
1082 should be aware that their judgment might be less than objective in cases involving  
1083 friends, family members, students, and colleagues and that providing “curbside” care  
1084 might sway the individual from establishing an ongoing relationship with a provider. If it  
1085 becomes necessary to treat a family member or close associate, a formal patient-provider  
1086 relationship should be established, and the PA should consider transferring the patient’s  
1087 care to another provider as soon as it is practical. If a close associate requests care, the  
1088 PA may wish to assist by helping them find an appropriate provider.

1089 There may be exceptions to this guideline, for example, when a PA runs an  
1090 employee health center or works in occupational medicine. Even in those situations, the  
1091 PA should be sure they do not provide informal treatment, but provide appropriate  
1092 medical care in a formally established patient-provider relationship.

### 1093 **Genetic Testing**

1094 Evaluating the risk of disease and performing diagnostic genetic tests raise  
1095 significant ethical concerns. PAs should be informed about the benefits and risks of  
1096 genetic tests. Testing should be undertaken only after proper informed consent is  
1097 obtained. If PAs order or conduct the tests, **OR HAVE ACCESS TO THE RESULTS AS**



1098 **A CONSEQUENCE OF PATIENT CARE**, they should assure that appropriate pre- and  
1099 post-test counseling is provided.

1100 PAs should be sure that patients understands the potential consequences of  
1101 undergoing genetic tests – from impact on patients themselves, possible implications for  
1102 other family members, and potential use of the information by insurance companies or  
1103 others who might have access to the information. Because of the potential for  
1104 discrimination by insurers, employers, or others, PAs should be particularly aware of the  
1105 need for confidentiality concerning genetic test results.

#### 1106 **Reproductive Decision Making**

1107 Patients have a right to access the full range of reproductive healthcare services,  
1108 including fertility treatments, contraception, sterilization, and abortion. PAs have an  
1109 ethical obligation to provide balanced and unbiased clinical information about  
1110 reproductive healthcare.

1111 When the PA's personal values conflict with providing full disclosure or  
1112 providing certain services such as sterilization or abortion, the PA need not become  
1113 involved in that aspect of the patient's care. By referring the patient to a qualified  
1114 provider who is willing to discuss and facilitate all treatment options, the PA fulfills their  
1115 ethical obligation to ensure the patient's access to all legal options.

#### 1116 **End of Life**

1117 Among the ethical principles that are fundamental to providing compassionate  
1118 care at the end of life, the most essential is recognizing that dying is a personal  
1119 experience and part of the life cycle.

1120 PAs should provide patients with the opportunity to plan for end of life care.  
1121 Advance directives, living wills, durable power of attorney, and organ donation should be  
1122 discussed during routine patient visits.

1123 PAs should assure terminally-ill patients that their dignity is a priority and that  
1124 relief of physical and mental suffering is paramount. PAs should exhibit non-judgmental  
1125 attitudes and should assure their terminally-ill patients that they will not be abandoned.  
1126 To the extent possible, patient or surrogate preferences should be honored, using the most  
1127 appropriate measures consistent with their choices, including alternative and non-  
1128 traditional treatments. PAs should explain palliative and hospice care and facilitate  
1129 patient access to those services. End of life care should include assessment and  
1130 management of psychological, social, and spiritual or religious needs.

1131 While respecting patients' **AND THEIR FAMILY'S** wishes for particular  
1132 treatments when possible, PAs also must weigh their ethical responsibility, **in**  
1133 **consultation with supervising physicians**, to withhold futile treatments, and help patients  
1134 understand such medical decisions. **THE SAME IS TRUE FOR EVALUATING A**  
1135 **REQUEST TO PROVIDE ASSISTANCE IN DYING.**

1136 **A PA SHOULD NOT MAKE THESE DECISIONS IN A VACUUM. PRIOR TO**  
1137 **TAKING ACTION, THEY THE PA SHOULD REVIEW INSTITUTIONAL POLICY**  
1138 **AND LEGAL STANDARDS. ,AND CONSULT A SUPERVISOR. A PA MAY**  
1139 **ALSO SHOULD ALSO CONSIDER SEEKING GUIDANCE FROM HOSPITAL**  
1140 **ETHICS COMMITTEE, AN ETHICIST, TRUSTED COLLEAGUES, A**  
1141 **SUPERVISOR, OR OTHER AAPA POLICIES.**

1142 PAs should involve the physician in all near death planning. **The PA should only**  
1143 **withdraw life support with the supervising physician's agreement and in accordance with**  
1144 **the policies of the healthcare institution.**

1145 **SEE ALSO, AAPA POLICY PAPER, END-OF-LIFE DECISION MAKING.**

1146 **The PA and Individual Professionalism**

1147 **Conflict of Interest**

1148 PAs should place service to patients before personal material gain and should  
1149 avoid undue influence on their clinical judgment. Trust can be undermined by even the  
1150 appearance of improper influence. Examples of excessive or undue influence on clinical  
1151 judgment can take several forms. These may include financial incentives, pharmaceutical  
1152 or other industry gifts, and business arrangements involving referrals. PAs should  
1153 disclose any actual or potential conflict of interest to their patients.

1154 Acceptance of gifts, trips, hospitality, or other items is discouraged. Before  
1155 accepting a gift or financial arrangement, PAs **might SHOULD** consider the guidelines of  
1156 **the Royal College of Physicians, “Would I be willing to have this arrangement generally  
1157 known?” or** of the American College of Physicians, “What would the public or my  
1158 patients think of this arrangement?” (4)

1159 **Professional Identity**

1160 PAs should not misrepresent directly or indirectly, their skills, training,  
1161 professional credentials, or identity. PAs should uphold the dignity of the PA profession  
1162 and accept its ethical values.

1163 **Competency**

1164 PAs should commit themselves to providing competent medical care and extend  
1165 to each patient the full measure of their professional ability as dedicated, empathetic  
1166 healthcare providers. **PROVIDING COMPETENT CARE INCLUDES SEEKING  
1167 CONSULTATION WITH OTHER PROVIDERS AND REFERRING PATIENTS  
1168 WHEN A PATIENT’S CONDITION EXCEEDS THE PA’S EDUCATION AND  
1169 EXPERIENCE, OR WHEN IT IS IN THE BEST INTEREST OF THE PATIENT.** PAs  
1170 should also strive to maintain and increase the quality of their healthcare knowledge,  
1171 cultural sensitivity, and cultural competence through individual study, **SELF-  
1172 REFLECTION SELF-ASSESSMENT** and continuing education.

1173 **Sexual Relationships**

1174 It is unethical for PAs to become sexually involved with patients. It also may be  
1175 unethical for PAs to become sexually involved with former patients or key third parties.  
1176 **THE LEGAL DEFINITION MAY VARY BY JURISDICTION, BUT** ~~key~~ key third parties  
1177 are **GENERALLY** individuals who have influence over the patient. ~~These might include~~  
1178 **SUCH AS** spouses or partners, parents, guardians, or surrogates. PAs should be aware of  
1179 and understand **INSTITUTIONAL POLICIES AND LOCAL,** state **AND FEDERAL**  
1180 laws **AND REGULATIONS** regarding sexual relationships.

1181 **SEXUAL** ~~Such~~ relationships generally are unethical because of the PA’s position  
1182 of authority and the inherent imbalance of knowledge, expertise, and status. Issues such  
1183 as dependence, trust, transference, and inequalities of power may lead to increased  
1184 vulnerability on the part of the current or former patients or key third parties.

1185 **HOWEVER, THERE ARE SOME CONTEXTS WHERE A STRICT**  
1186 **MORATORIUM, PARTICULARLY WHEN EXTENDED TO THIRD PARTIES, MAY**  
1187 **NOT BE FEASIBLE (3). IN THESE CASES, THE PA SHOULD SEEK ADDITIONAL**  
1188 **RESOURCES OR GUIDANCE FROM A SUPERVISOR, A HOSPITAL ETHICS**  
1189 **COMMITTEE, AN ETHICIST OR TRUSTED COLLEAGUES. PAS SHOULD SEEK**  
1190 **LEGAL COUNSEL WHEN THEY ARE CONCERNED ABOUT THE POTENTIAL**  
1191 **LEGAL CONSEQUENCES OF THEIR DECISIONS.**

1192 **~~Gender Discrimination and Sexual Harassment~~ NONDISCRIMINATION IN THE**  
1193 **WORKPLACE AND CLASSROOM**



1194 It is unethical for PAs to engage in or condone any form of gender,  
1195 discrimination. Gender Discrimination is defined as any behavior, action, or policy that  
1196 adversely affects an individual or group of individuals due to disparate treatment,  
1197 disparate impact, or the creation of a hostile, INEQUITABLE or intimidating work or  
1198 learning environment. THIS INCLUDES, BUT IS NOT LIMITED TO,  
1199 DISCRIMINATION BASED ON GENDER, SEX, COLOR, CREED, RACE,  
1200 RELIGION, AGE, ETHNIC OR NATIONAL ORIGIN, POLITICAL BELIEFS,  
1201 NATURE OF ILLNESS, DISABILITY, SOCIOECONOMIC STATUS, PHYSICAL  
1202 STATURE, BODY SIZE, GENDER IDENTITY, MARITAL STATUS, OR  
1203 SEXUAL ORIENTATION.

1204 SEE ALSO THE SECTIONS ON NONDISCRIMINATION OF PATIENTS AND  
1205 FAMILIES, AND SEXUAL HARASSMENT.

#### 1206 **SEXUAL HARASSMENT**

1207 It is unethical for PAs to engage in or condone any form of sexual harassment.  
1208 Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors,  
1209 or other verbal or physical conduct of a sexual nature when:

- 1210 • Such conduct has the purpose or effect of interfering with an individual's work or  
1211 academic performance or creating an intimidating, hostile or offensive work or  
1212 academic environment,
- 1213 • Accepting or rejecting such conduct affects or may be perceived to affect  
1214 professional decisions concerning an individual, or
- 1215 • Submission to such conduct is made either explicitly or implicitly a term or  
1216 condition of an individual's training or professional position.

1217 SEE ALSO THE SECTION ON NONDISCRIMINATION IN THE WORKPLACE  
1218 AND CLASSROOM.

#### 1219 **The PA and Other Professionals**

##### 1220 **Team Practice**

1221 PAs should be committed to working collegially with other members of the  
1222 healthcare team to assure integrated, well-managed, and effective care of patients. PAs  
1223 should strive to maintain a spirit of cooperation with other healthcare professionals, their  
1224 organizations, and the general public. THE PA SHOULD CONSULT WITH ALL  
1225 APPROPRIATE TEAM MEMBERS WHENEVER IT WILL SAFEGUARD OR  
1226 ADVANCE THE WELFARE OF THE PATIENT. THIS INCLUDES SEEKING  
1227 ASSISTANCE IN SITUATIONS OF CONFLICT WITH A PATIENT OR ANOTHER  
1228 HEALTHCARE PROFESSIONAL.

##### 1229 **RESOLUTION OF CONFLICT BETWEEN PROVIDERS**

1230 WHILE A PA'S FIRST RESPONSIBILITY IS THE BEST INTEREST OF THE  
1231 PATIENT, IT IS INEVITABLE THAT PROVIDERS WILL SOMETIMES DISAGREE  
1232 WHEN WORKING AS MEMBERS OF A HEALTHCARE TEAM. WHEN  
1233 CONFLICTS ARISE BETWEEN PROVIDERS IN REGARDS TO PATIENT CARE, IT  
1234 IS IMPORTANT THAT PATIENT AUTONOMY AND THE PATIENT'S TRUSTED  
1235 RELATIONSHIP WITH EACH MEMBER OF THE HEALTHCARE TEAM ARE  
1236 PRESERVED. IF PROVIDERS DISAGREE ON THE COURSE OF ACTION, IT IS  
1237 THEIR RESPONSIBILITY TO DISCUSS THE OPTIONS OPENLY AND HONESTLY  
1238 WITH EACH OTHER, AND COLLABORATIVELY WITH THE PATIENT.

1239 IT IS UNETHICAL FOR A PA TO CIRCUMVENT THE OTHER MEMBERS  
1240 OF THE HEALTHCARE TEAM OR ATTEMPT TO DISPARAGE OR DISCREDIT  
1241 OTHER MEMBERS OF THE TEAM WITH THE PATIENT. IN THE EVENT A PA

1242 HAS LEGITIMATE CONCERNS ABOUT A PROVIDER'S COMPETENCY OR  
1243 INTENT, THOSE CONCERNS SHOULD BE REPORTED TO THE PROPER  
1244 AUTHORITIES.

1245 PAS SHOULD BE AWARE OF AND TAKE ADVANTAGE OF AVAILABLE  
1246 EMPLOYER RESOURCES, IF AVAILABLE, TO MITIGATE AND RESOLVE  
1247 CONFLICTS BETWEEN PROVIDERS.

#### 1248 **Illegal and Unethical Conduct**

1249 PAs should not participate in or conceal any activity that will bring discredit or  
1250 dishonor to the PA profession. They should report illegal or unethical conduct by  
1251 healthcare professionals to the appropriate authorities.

#### 1252 **Impairment**

1253 PAs have an ethical responsibility to protect patients and the public by  
1254 RECOGNIZING THEIR OWN IMPAIRMENT AND identifying and assisting impaired  
1255 colleagues. "Impaired" means being unable to practice medicine with reasonable skill and  
1256 safety because of physical or mental illness, loss of motor skills, or excessive use or  
1257 abuse of drugs and alcohol.

1258 PAs should be able to recognize impairment in physician supervisors, PAs, and  
1259 other health care providers ANY MEMBER OF THE HEALTHCARE TEAM and  
1260 should seek assistance from appropriate resources to encourage these individuals to  
1261 obtain treatment.

1262 *SEE ALSO, AAPA POLICY PAPER, PA IMPAIRMENT.*

#### 1263 **PA-Physician Relationship**

1264 Supervision should include ongoing communication between the physician and  
1265 the PA regarding patient care. The PA should consult the supervising physician whenever  
1266 it will safeguard or advance the welfare of the patient. This includes seeking assistance in  
1267 situations of conflict with a patient or another healthcare professional.

#### 1268 **Complementary, and Alternative AND INTEGRATIVE HEALTH Medicine**

1269 When a patient asks about COMPLEMENTARY, ALTERNATIVE AND/OR  
1270 HEALTH APPROACHES OR INTEGRATIVE HEALTH APPROACHES an  
1271 alternative therapy, the PA has an ethical obligation to gain a basic understanding of the  
1272 alternative therapy THERAPY(IES) being considered or being used and how the  
1273 treatment will affect the patient. PAS SHOULD DO APPROPRIATE RESEARCH,  
1274 INCLUDING SEEKING ADVICE FROM COLLEAGUES WHO HAVE  
1275 EXPERIENCE WITH THE TREATMENT OR EXPERTS IN THE THERAPEUTIC  
1276 FIELD. If the PA BELIEVES THE treatment would harm COMPLEMENTARY,  
1277 ALTERNATIVE OR INTEGRATIVE HEALTH IS NOT IN THE BEST INTEREST OF  
1278 the patient, the PA should work diligently to dissuade the patient from using it, advise  
1279 other treatment, and perhaps consider transferring the patient to another provider.

1280 *SEE ALSO, AAPA POLICY PAPER: COMPLEMENTARY AND ALTERNATIVE*  
1281 *MEDICINE (CAM)*

#### 1282 **The PA and the Healthcare System**

##### 1283 **Workplace Actions**

1284 PAs may face difficult personal decisions to withhold medical services when  
1285 workplace actions (e.g., strikes, sick-outs, slowdowns, etc.) occur. The potential harm to  
1286 patients should be carefully weighed against the potential improvements to working  
1287 conditions and, ultimately, patient care that could result. In general, PAs should  
1288 individually and collectively work to find alternatives to such actions in addressing  
1289 workplace concerns.

1290 **PAs as Educators**

1291 All PAs have a responsibility to share knowledge and information with patients,  
1292 other health professionals, students, and the public. The ethical duty to teach includes  
1293 effective communication with patients so that they will have the information necessary to  
1294 participate in their healthcare and wellness.

1295 *SEE ALSO, AAPA POLICY PAPER, PA STUDENT SUPERVISED CLINICAL*  
1296 *PRACTICE EXPERIENCES - RECOMMENDATIONS TO ADDRESS BARRIERS.*

1297 **PAs and Research**

1298 The most important ethical principle in research is honesty. This includes assuring  
1299 subjects' informed consent, following treatment protocols, and accurately reporting  
1300 findings. Fraud and dishonesty in research ~~MUST should~~ be reported **TO MAINTAIN**  
1301 **THE INTEGRITY OF THE AVAILABLE DATA IN RESEARCH.** ~~so that the~~  
1302 ~~appropriate authorities can take action.~~

1303 **PAS ARE ENCOURAGED TO WORK WITHIN THE OVERSIGHT OF**  
1304 **INSTITUTIONAL REVIEW BOARDS AND INSTITUTIONAL ANIMAL CARE AND**  
1305 **USE COMMITTEES AS A MEANS TO ENSURE THAT ETHICAL STANDARDS**  
1306 **ARE MAINTAINED.**

1307 PAs involved in research must be aware of potential conflicts of interest. ~~The~~  
1308 ~~patient's welfare takes precedence over the desired research outcome.~~ Any conflict of  
1309 interest ~~MUST should~~ be disclosed. **THE PATIENT'S WELFARE TAKES**  
1310 **PRECEDENCE OVER THE PROPOSED RESEARCH PROJECT.**

1311 **PAS ARE ENCOURAGED TO UNDERGO RESEARCH ETHICS**  
1312 **EDUCATION THAT INCLUDES PERIODIC REFRESHER COURSES TO BE**  
1313 **MAINTAINED THROUGHOUT THE COURSE OF THEIR RESEARCH ACTIVITY.**  
1314 **PAS MUST BE EDUCATED ON THE PROTECTION OF VULNERABLE**  
1315 **RESEARCH POPULATIONS.**

1316 ~~In scientific writing, PAs must should report information honestly and accurately.~~  
1317 Sources of funding for the research must be included in the published reports.

1318 **THE SECURITY OF PERSONAL HEALTH DATA MUST BE MAINTAINED**  
1319 **TO PROTECT PATIENT PRIVACY.**

1320 Plagiarism is unethical. Incorporating the words of others, either verbatim or by  
1321 paraphrasing, without appropriate attribution is unethical and may have legal  
1322 consequences. When submitting a document for publication, any previous publication of  
1323 any portion of the document must be fully disclosed.

1324 **PAs as Expert Witnesses**

1325 The PA expert witness should testify to what ~~he or she~~ **THEY** believes to be the  
1326 truth. The PA's review of medical facts should be thorough, fair, and impartial.

1327 The PA expert witness should be fairly compensated for time spent preparing,  
1328 appearing, and testifying. The PA should not accept a contingency fee based on the  
1329 outcome of a case in which testimony is given or derive personal, financial, or  
1330 professional favor in addition to compensation.

1331 *SEE ALSO, AAPA POLICY PAPER, GUIDELINES FOR THE PA SERVING AS*  
1332 *AN EXPERT WITNESS.*

1333 **The PA and Society**

1334 **Lawfulness**

1335 PAs have the dual duty to respect the law and to work for positive change to laws  
1336 that will enhance the health and well-being of the community.

1337 **Executions**

1338 PAs, as healthcare professionals, should not participate in executions because to  
1339 do so would violate the ethical principle of beneficence.

1340 **SEE ALSO AAPA POLICY HX-4100.1.9.**

#### 1341 **Access to Care / Resource Allocation**

1342 PAs have a responsibility to use healthcare resources in an appropriate and  
1343 efficient manner so that all patients have access to needed healthcare. Resource allocation  
1344 should be based on societal needs and policies, not the circumstances of an individual  
1345 patient–PA encounter. (1) PAs participating in policy decisions about resource allocation  
1346 should consider medical need, cost-effectiveness, efficacy, and equitable distribution of  
1347 benefits and burdens in society.

#### 1348 **Community Well Being**

1349 PAs should work for the health, well-being, and the best interest of both the  
1350 patient and the community. Sometimes there is a dynamic moral tension between the  
1351 well-being of the community in general and the individual patient. Conflict between an  
1352 individual patient’s best interest and the common good is not always easily resolved.

1353 **WHEN CONFRONTED WITH THIS SITUATION, A PA MAY SEEK GUIDANCE**  
1354 **FROM A SUPERVISOR, A HOSPITAL ETHICS COMMITTEE, AN ETHICIST,**  
1355 **TRUSTED COLLEAGUES, OR OTHER AAPA POLICIES.**

1356 In general, PAs should be committed to upholding and enhancing community  
1357 values, be aware of the needs of the community, and use the knowledge and experience  
1358 acquired as professionals to contribute to an improved community.

#### 1359 **Conclusion**

1360 AAPA recognizes its responsibility to aid the PA profession as it strives to  
1361 provide high quality, accessible healthcare. PAs wrote these guidelines for themselves  
1362 and other PAs. The ultimate goal is to honor patients and earn their trust while providing  
1363 the best and most appropriate care possible. At the same time, PAs must understand their  
1364 personal values and beliefs and recognize the ways in which those values and beliefs can  
1365 impact the care they provide.

#### 1366 **REFERENCES**

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1368 University Press, 2008
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1370 *in Clinical Medicine*, 8<sup>th</sup> Edition, McGraw-Hill Professional Publishing, 2015
- 1371 3. Nelson, W *Handbook for Rural Health Care Ethics: A Practical Guide for*  
1372 *Professionals*, 1<sup>st</sup> Edition; Dartmouth College Press, 2009.  
1373 <https://geiselmed.dartmouth.edu/cfm/resources/ethics/full-book.pdf>
- 1374 4. American College of Physician’s Ethical Manual, Sixth Edition.  
1375 [https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-](https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-sixth-edition/acp-ethics-manual-sixth-edition)  
1376 [ethics-manual-sixth-edition/acp-ethics-manual-sixth-edition](https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-sixth-edition/acp-ethics-manual-sixth-edition)
- 1377 5. American Medical Association’s Code of Medical Ethics. [https://www.ama-](https://www.ama-assn.org/delivering-care/ama-code-medical-ethics)  
1378 [assn.org/delivering-care/ama-code-medical-ethics](https://www.ama-assn.org/delivering-care/ama-code-medical-ethics)
- 1379 6. **AAPA Policy Papers:**

1380  
1381 **#5. [Guidelines for the PA Serving as an Expert Witness](#) (Adopted 1977,**  
1382 **reaffirmed 2004, 2009, amended 1987, 1991, 2001, 2014) Cited at HP-3700.1.5**

1383  
1384 **#8 [PA Impairment](#) (Adopted 1990, amended 1992, 2009, reaffirmed 2004, 2014)**  
1385 **Cited at HP-3700.1.3**

- 1386  
1387 #12 [End-of-Life Decision Making](#) (Adopted 1997, amended 2009, reaffirmed  
1388 2004, 2014) *Cited at HP-3700.1.4*  
1389  
1390 #14 [Complementary and Alternative Medicine](#) (Adopted 1999, amended 2005,  
1391 2009, reaffirmed 2004, 2014) *Cited at HP-3300.1.14*  
1392  
1393 #17 [Use of Medical Interpreters for Patients with Limited English Proficiency](#)  
1394 (Adopted 2003, reaffirmed 2008, 2013) *Cited at HP-3300.2.10*  
1395  
1396 #31 [Acknowledging and Apologizing for Adverse Outcomes](#) (Adopted 2007,  
1397 reaffirmed 2012, amended 2013) *Cited at HP-3800.2.2*  
1398  
1399 #33 [Health Disparities: Promoting the Equitable Treatment of All Patients](#)  
1400 (Adopted 2011, amended 2016) *Cited at HX-4600.1.6.1*  
1401  
1402 #38 [PA Student Supervised Clinical Practice Experiences - Recommendations to](#)  
1403 [Address Barriers](#) (Adopted 2017) *Cited at HP-3200.1.6*  
1404  
1405 #39 [Attempts to Change a Minor's Sexual Orientation, Gender Identity, or Gender](#)  
1406 [Expression](#) (Adopted 2017) *Cited at HX-4200.6.2*  
1407

#### 2018-A-14 – Adopted on Consent Agenda

1409  
1410 The AAPA House of Delegates will appoint a task force of subject matter experts to  
1411 develop a policy paper on genetic testing to be presented as a resolution to the 2019  
1412 HOD.  
1413

#### 2018-A-15 – Adopted on Consent Agenda

1414  
1415 Amend policy HP-3700.1.4 entitled “End-Of-Life Decision Making” as follows:  
1416  
1417

1418 **Only sections of the policy paper with proposed amendments are presented.**  
1419 **The entire paper can be found in the policy manual.**  
1420

##### **End-of-Life Decision Making**

1421  
1422 *(Adopted 1997, amended 2009, reaffirmed 2004, 2014)*  
1423

##### **Legal Issues at the End of Life**

1424  
1425 (22) The following definitions may help to clarify discussions about end-of-life decisions.

1426 (23) **Suicide:** the intentional taking of one's own life.

1427 (24) **Assisted suicide:** providing information, medication (or other means) or direct  
1428 assistance that enables a person to take ~~his or her~~ **THEIR** own life. The final action  
1429 remains with the person who wishes to die.

1430 (25) **Euthanasia:** deliberately bringing about the death of another to spare the individual  
1431 suffering. In this context, a painless and humane death delivered to a person who is  
1432 terminally ill.

1433 (26) **Passive euthanasia:** the act of withdrawing support or intervention necessary to  
1434 keep a patient alive, such as unplugging a ventilator or stopping parenteral feeding.  
1435 (27) **Active euthanasia:** direct intervention by another person to cause death, for  
1436 example, by injecting a lethal dose of a drug.  
1437 (28) **Voluntary euthanasia:** performed on a patient who has made clear the wish to die,  
1438 but is unable to act on it.<sup>11</sup>  
1439 (29) **Double effect euthanasia:** provision of palliative treatment that may have fatal side  
1440 effects; i.e., steadily rising doses of morphine, intended to control pain and agitation, also  
1441 "inadvertently" hasten death by depressing respiration.<sup>12</sup>  
1442 (30) **Terminal sedation:** after removal of life sustaining devices, a person is heavily  
1443 sedated for comfort until death occurs.  
1444 (31) **Advance directive:** explicit instructions and guidelines regarding an individual's  
1445 desires for treatment, comfort, and resuscitative efforts in the event of terminal illness or  
1446 incapacitation.  
1447 (32) Suicide or attempted suicide, while not technically legal, is not prosecuted or  
1448 punished in any state. All states, however, have prohibitions on intentionally causing the  
1449 death of another or inducing an individual to commit suicide. At present, assisted suicide  
1450 is explicitly banned in at least 30 states.<sup>13</sup> On March 6, 1996, the first physician-assisted  
1451 suicide case decided at the federal appellate level found a Washington state ban on  
1452 physician-assisted suicide to be unconstitutional. The law in question had allowed  
1453 "passive" withdrawal or withholding of life support, but prohibited "active" assisted  
1454 suicide. The decision by the US Court of Appeals for the Ninth Circuit affirmed and  
1455 clarified a 1994 judgment that had declared the state law unconstitutional. In an 8-3  
1456 decision, the appellate court stated, "We hold that insofar as the Washington statute  
1457 prohibits physicians from prescribing life-ending medication for use by terminally ill,  
1458 competent adults who wish to hasten their own deaths, it violates the Due Process Clause  
1459 of the Fourteenth Amendment (to the US Constitution)."<sup>14</sup>  
1460 (33) Less than a month after the Ninth Circuit Court decision, the US Court of Appeals  
1461 for the Second Circuit struck down a New York law prohibiting assisted suicide. The  
1462 court found the state had no rational basis for distinguishing between competent,  
1463 terminally ill patients who may legally choose to refuse medical treatment or have care  
1464 withdrawn, and patients who choose to end their lives by self-administration of drugs  
1465 prescribed by their physicians. The court held that "physicians who are willing to do so  
1466 may prescribe drugs to be self-administered by mentally competent patients who seek to  
1467 end their lives during the final stages of a terminal illness."<sup>15</sup>  
1468 (34) The states of Washington and New York appealed the two circuit court decisions to  
1469 the US Supreme Court, which heard the case on January 8, 1997. The Supreme Court  
1470 ruled that terminally ill patients do not have a constitutionally protected right to assisted  
1471 suicide. The ruling against a constitutional right refers the issue back into state  
1472 legislatures and courts.<sup>16</sup>  
1473 (35) The risk of criminal liability in withdrawing or withholding life support at the  
1474 request of a patient or surrogate is exceedingly small. Risk increases somewhat if a  
1475 clinician directly causes a patient's death by administering a lethal dose of medicine.  
1476 "Assisting" in a suicide by providing medical advice or means (e.g., a prescription) also  
1477 carries significant risk of prosecution.<sup>18</sup> In 1999, a Michigan court convicted Dr. Jack  
1478 Kevorkian of second degree murder for administering a lethal injection to a patient  
1479 suffering from Lou Gehrig's Disease (People vs. Kevorkian). He was sentenced to 10-25



1480 years' imprisonment. Conviction in such cases is rare if the clinician has acted ethically  
1481 and compassionately in accordance with the patient's wishes.

1482 (36) Several states have mounted efforts to legalize assisted suicide. A 1991 initiative --  
1483 also in the state of Washington -- was defeated in a general election by a 54 to 46% vote.  
1484 Although the bill's underlying premise seemed to elicit substantial support, there was also  
1485 strong concern about inadequate safeguards against potential abuse. A year later, a  
1486 similar initiative in California with broader safeguards was defeated by a similar margin.  
1487 In 1994, Oregon voters passed a measure permitting a physician to supply a terminally ill  
1488 patient with a prescription for a lethal amount of drugs, the Death with Dignity Act. The  
1489 hotly contested bill, which passed by a narrow margin, was actively opposed by the  
1490 American Medical Association, and its implementation blocked by litigation.<sup>19</sup> In 2006,  
1491 the United States Supreme Court upheld the Oregon Death with Dignity Act in a 6-3  
1492 opinion. The court rules that the controlled substances act does not prohibit the use of  
1493 controlled substances for physician-assisted suicide (Gonzales vs. Oregon no. 04-623).

1494 (37) In 2005, the United States Supreme Court upheld the right of the Florida State Court  
1495 to order the removal of a feeding tube in the case of Terri Schiavo. It was the sixth time  
1496 the Supreme Court refused to intervene in the prolonged litigation between the patient's  
1497 husband and parents.

1498 (38) The debate over assisted suicide points up the distinction between *legalizing* an  
1499 action and *decriminalizing* it. Legalization makes an action legal in a defined set of  
1500 circumstances. Decriminalization maintains the prohibition against an action, but reduces  
1501 the gravity of the charge and the severity of the penalty, usually to a misdemeanor.  
1502 Absence of criminal liability by no means precludes the possibility of civil liability, such  
1503 as suits for medical malpractice or wrongful death.

1504 (39) After including safeguards against abuse, in 2008, initiative 1000, the Washington  
1505 State Death with Dignity Act, was approved by 58% of votes. The law, which closely  
1506 imitates the Oregon Death with Dignity Act, went into effect March 6, 2009. The act  
1507 allows a competent adult with a terminal illness to make a written request for medication  
1508 to be self-administered to end ~~his or her~~ **THEIR** life. The act includes civil, criminal, and  
1509 professional disciplinary safeguards for providers who participate in the patient's request.

1510 (40) Another law that has exerted substantial impact on end-of-life decision making is the  
1511 Patient Self-Determination Act (PL 101-508, 104 Stat 1388-321), enacted as an  
1512 amendment to Medicare statutes in 1990. This act required states to develop or enact  
1513 measures to inform patients of their decision making rights regarding treatment, life  
1514 support, and resuscitation. Details vary from state to state, but the goal of alerting patients  
1515 to their options regarding advance directives upon admission to a hospital or nursing  
1516 home has been broadly realized.

1517 **Ethical Considerations**

1518 (41) Ethics, or principles of moral conduct, are not fixed and static, but subject to change  
1519 and interpretation. Social, historical, cultural, racial, political, professional, and religious  
1520 influences all shape the ethical beliefs that affect the actions of health care providers and  
1521 patients.

1522 (42) Four generally accepted principles of bioethics are autonomy, beneficence,  
1523 nonmaleficence, and justice.

1524 (43) **Autonomy**, strictly speaking, is self-rule. To be truly autonomous, one must be  
1525 capable of making decisions and choices.<sup>20</sup>

1526 (44) **Beneficence** is acting in what is (or is judged to be) the patient's best interest. It is  
1527 often equated with paternalism.



1528 (45) **Nonmaleficence** means to do no harm, to impose no unnecessary or unacceptable  
1529 burden upon the patient.

1530 (46) **Justice** means that patients in similar circumstances should receive similar care. It  
1531 also refers to norms for the fair distribution of resources, risks, and costs.

1532 (47) For centuries, the healing professions, like the clergy, assumed a parental role.  
1533 Physicians possessed a storehouse of scientific knowledge not accessible to the general  
1534 public. Their healing endeavors were often cloaked in ritual and quasi-mysticism.  
1535 Patients were considered incapable of choosing among complicated scientific theories,  
1536 and physicians were expected to choose for them. Thus emerged the concept of the  
1537 beneficent healer, and society came to accept medical paternalism and beneficence as  
1538 one.

1539 (48) Over the past three decades, a gradual but inexorable shift has taken place in the  
1540 field of bioethics. Patients have become better educated and more capable of  
1541 understanding scientific data. Medicine has become more accessible and somewhat de-  
1542 mystified. From the mid-1960s on, authority figures -- physicians included -- have been  
1543 subject to more challenge and scrutiny. As money has become more a focus of health  
1544 care decisions and debate, physicians' aura of moral authority has eroded.

1545 (49) In this milieu of change, patient autonomy has evolved as the primary precept of  
1546 bioethics. In the last 20 years, substantial reforms have been undertaken in the fields of  
1547 law, ethics, and medical education, all revolving around the patient's right to choose.<sup>1</sup>  
1548 Often, it is assumed that the principles of autonomy and beneficence are in conflict. This  
1549 is true if one equates beneficence and paternalism, but the terms are not equivalent or  
1550 interchangeable. In some circumstances, paternalism might be maleficent -- for example,  
1551 if it violates a patient's right to choose. And beneficence may be far from paternal, since  
1552 it may consist of educating the patient to enable ~~his or her~~ **THEIR** informed choice.  
1553 Beneficence may complement autonomy.

1554 (50) Nonmaleficence as an ethical principle requires that a provider "first, do no harm."  
1555 This is a tangled issue in end-of-life decision making, since the same acts may be  
1556 interpreted as harmful or beneficial depending on the circumstances and on participants'  
1557 values and perspectives. For example, if a comatose patient with no advance directive is  
1558 kept on life support in the ICU, is not harm inflicted through physical discomfort and  
1559 financial hardship? On the other hand, if life support is withdrawn, is the patient not  
1560 harmed by being deprived of even the remotest chance of recovery?

1561 (51) The principle of justice is not a simplistic implication that all patients should receive  
1562 the same treatments and resources. It does require that all patients be accorded respect for  
1563 their individuality and autonomy. All should receive the same opportunity to be informed  
1564 and choose their course of treatment. It also requires that scarce resources be allocated  
1565 fairly (for example, on patients with a good chance of recovery rather than on those for  
1566 whom treatment will be futile).<sup>21</sup>

1567 **Cooperative End-of-Life Decision Making**

1568 (52) A society's beliefs are reflected in its laws and ethical principles. The individual  
1569 struggling with difficult decisions about death and dying can turn to those principles for  
1570 guidance, but will rarely find that they provide all the answers. Ultimately, death is not  
1571 societal but solitary and supremely personal. However, as medicine has succeeded in  
1572 prolonging life, greater numbers of people have become enmeshed in the process of an  
1573 individual's death. At the dying patient's bedside are family, loved ones, clergy, health  
1574 care providers, technicians and, in absentia, lawyers, ethicists, and even third-party  
1575 payers. Each brings a set of priorities, beliefs, and values, and achieving complete

1576 harmony among them is usually impossible. If the goal of end-of-life decision making is  
1577 to make the process of dying as humane and compassionate as possible, it is essential to  
1578 minimize conflict and maximize cooperation for the patient's benefit. One way to  
1579 enhance cooperation is by understanding the internal and external influences that affect  
1580 the patient, ~~his or her~~ **THE PATIENT'S** family, and clinicians, especially physicians and  
1581 PAs.

1582

1583 **2018-A-16 – Adopted on Consent Agenda**

1584

1585 Amend policy HP-3200.1.6 PA entitled “Student Supervised Clinical Practice  
1586 Experiences – Recommendations to Address Barriers” as follows:

1587

1588 **Only the paragraph with a proposed amendment is presented.**

1589

**The entire paper can be found in the policy manual.**

1590

1591 **PA Student Supervised Clinical Practice Experiences –**

1592

**Recommendations to Address Barriers**

1593

*(Adopted 2017)*

1594

1595 One of the most commonly cited concerns among survey participants was the lack  
1596 of clear understanding about the expectations of precepting a student. While some of  
1597 these expectations are specific to each program, many aspects of precepting are universal.  
1598 Respondents repeatedly suggested that a standard precepting toolkit or workshops that  
1599 guide preceptors in the basic requirements of teaching PA students would be beneficial.  
1600 This could be achieved through the development of a standardized “PA student passport”  
1601 or educational checklist that would be common to all PA students and that might include  
1602 a summary of a student’s didactic education and the skills that ~~he or she~~ **PA STUDENTS**  
1603 are reasonably expected to perform. This could also be achieved by the implementation  
1604 of Entrustable Professional Activities (EPAs) into PA education, which will be further  
1605 discussed in the section on Long-Term Solutions. Survey participants also reported  
1606 wanting more resources regarding best practices and teaching in a clinical setting.

1607

1608 **2018-A-17 – Adopted on Consent Agenda**

1609

1610 Amend policy HP-3200.4.1 entitled “Accreditation and Implications of Clinical  
1611 Postgraduate PA Training Programs” as follows:

1612

1613 **Only sections of the policy paper with proposed amendments are presented.**

1614

**The entire paper can be found in the policy manual.**

1615

1616 **Accreditation and Implications of Clinical Postgraduate PA Training**

1617

**Programs**

1618

*(Adopted 2005, amended 2010, 2016)*

1619

1620 **Executive Summary of Policy Contained in this Paper**

1621

Summaries will lack rationale and background information and may lose nuance of  
1622 policy. You are highly encouraged to read the entire paper.

1623

- 1624
- 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.
- 1625
- 1626
- 1627

1628 **Summary**

1629 Clinical postgraduate PA training programs represent one of many innovations  
1630 created by the PA profession to support continuing professional development and lifelong  
1631 learning, foster interprofessional and collaborative care, advance workforce development  
1632 and explore novel educational approaches to optimize healthcare delivery. Since 1971,  
1633 clinical postgraduate PA training programs have provided a relatively small number of  
1634 interested PAs with diverse opportunities to gain advanced clinical skills and experience  
1635 in the workplace, building upon the generalist medical education offered to all PAs  
1636 through entry-level PA education. Similar to the impetus of physician shortages that led  
1637 to the birth of the PA profession, many of the early clinical postgraduate PA training  
1638 programs arose to address provider shortages that resulted from duty-hour restrictions of  
1639 medical residents. Advanced training in the clinical setting is a core facet of the  
1640 professional identity formation and continuing medical education **for every PA**  
1641 **throughout his or her THROUGHOUT EVERY PA'S** career. Advanced training in the  
1642 clinical setting, a generalist foundation for entry-level PA education, and generalist  
1643 model for certification together position the PA profession as one of the most flexible and  
1644 adaptable professions in modern healthcare. This flexibility and capacity to adopt and  
1645 adapt to dynamic changes in healthcare delivery make PAs invaluable assets within the  
1646 U.S. healthcare workforce to improve access and improve the quality of patient-centered  
1647 care for patients, families, and communities. The development of an efficient, PA-led,  
1648 national model for accreditation, continuous quality improvement, and reporting on  
1649 outcomes is needed. Greater investment in research infrastructures is needed to support  
1650 knowledge generation, dissemination of best practices, and optimization of these  
1651 voluntary, workplace-based educational innovations for PAs.

1652

1653 **2018-A-18 – Adopted on Consent Agenda**

1654

1655 Amend policy HP-3300.1.15 entitled “Immunizations in Children and Adults” as follows:

1656

1657 **Only sections of the policy paper with proposed amendments are presented.**  
1658 **The entire paper can be found in the policy manual.**

1659

1660 **Immunizations in Children and Adults**

1661 *(Adopted 1994, amended 2004, 2006, 2011, 2016)*

1662

- 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.
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1671 **2018-A-19 – Adopted on Consent Agenda**

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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 Guidelines<sup>11</sup> as well as accreditation standards from the Joint Commission<sup>12</sup> specifically require a fair hearing and appeals process for addressing adverse

1720 decisions made against medical staff members and others holding clinical privileges. The  
1721 process should include PA peer reviewers.

1722 **Participation in Disaster and Emergency Care**

1723 The bylaws should include language enabling PAs to provide care during emergency  
1724 or disaster situations. The bylaws should state that the chief executive or ~~his or her~~ **THE**  
1725 **CHIEF EXECUTIVE'S** designee may grant temporary clinical privileges when appropriate  
1726 and that emergency privileges may be granted when the hospital's emergency management  
1727 plan has been activated. The hospital's emergency preparedness plan should include PAs in  
1728 its identification of care providers authorized to respond in emergency or disaster situations.

1729 Bylaws language might state:

1730 In case of an emergency, any member of the medical staff, house staff, and any licensed  
1731 health practitioner, limited only by the qualifications of their license and regardless of service  
1732 or staff status, shall be permitted to render emergency care. They will be expected to do  
1733 everything possible to save the life of a patient, utilizing all resources of the hospital as  
1734 necessary, including the calling of any consultations necessary or desirable. Any PA or  
1735 physician acting in an emergency or disaster situation shall be exempt from the hospital's  
1736 usual bylaws provisions to the extent allowed by state law in disaster or emergency  
1737 situations.

1738 **Conclusion**

- 1739 • PAs must seek delineation of their clinical privileges. The process and criteria for  
1740 which must be outlined in medical staff bylaws.
- 1741 • PAs should be voting members of the medical staff.
- 1742 • Medical staff bylaws should require that each PA be granted clinical privileges to  
1743 provide medical care to patients in the facility, regardless of by whom that PA is  
1744 employed.
- 1745 • AAPA opposes specialty certification examinations as a requirement for PA  
1746 credentialing or privileging.
- 1747 • Duration of appointments and privileges should be the same for physicians and PAs.
- 1748 • Bylaws should give PAs the right to due process when actions taken by the organized  
1749 medical staff or governing board adversely affect ~~his or her~~ **THE PA'S** clinical  
1750 privileges.
- 1751 • The criteria and process for corrective action should be spelled out for PAs in the  
1752 bylaws. The process should involve PA peers and conform to the process applied to  
1753 physicians
- 1754 • Bylaws should provide mechanisms to carry out quality assurance with respect to  
1755 PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the  
1756 same area of clinical specialty.
- 1757 • Bylaws should require PA participation in continuing medical education that relates  
1758 to their practice and their privileges.
- 1759 • Bylaws should allow PA representation on standing medical staff committees,  
1760 including the medical executive committee, credentialing committees, and others.
- 1761 • Bylaws should include language enabling PAs to provide care during emergency or  
1762 disaster situations.

1763

1764 **2018-A-20 – Adopted on Consent Agenda**

1765

1766 Amend policy HP-3500.4.1 as follows:

1767



1768 AAPA opposes the use of non-compete clauses in PA’s employment contracts. These  
1769 covenants violate a PA’s right to practice ~~his or her~~ **THEIR** profession, negatively impact  
1770 various aspects of patient care and access to care, and ultimately put financial interests  
1771 ahead of patient and community care.

1772  
1773 **2018-A-21 – Adopted on Consent Agenda**

1774  
1775 Amend policy HP-3700.1.3.2 as follows:

1776  
1777 AAPA shall support in principle the chemically dependent PA who has acknowledged  
1778 ~~his/her~~ **THEIR** illness, engaged in a recovery program, and persists in a lifestyle  
1779 compatible with ongoing recovery.

1780  
1781 **2018-A-22 – Adopted as Amended**

1782  
1783 Amend policy HX-3700.1.5 entitled “Guidelines for the PA Serving as an Expert  
1784 Witness”.

1785  
1786 **Guidelines for the PA Serving as an Expert Witness**

1787 (Adopted 1977, reaffirmed 2004, 2009, amended 1987, 1991, 2001, 2014)

1788  
1789 **Only sections of the policy paper with proposed amendments are presented here.**  
1790 **The entire paper can be found in the policy manual.**

1791  
1792 **Executive Summary of Policy Contained in this Paper**

1793 Summaries will lack rationale and background information and may lose nuance of  
1794 policy. You are highly encouraged to read the entire paper.

- 1795  
1796
- 1797 • A PA serving as an expert witness should have current experience and knowledge in the  
1798 area(s) about which ~~he or she~~ **THE PA** is to testify.
  - 1799 • A PA expert must objectively evaluate facts and provide an opinion. If no opinion can be  
1800 derived from available facts, this should be stated to the attorney.
  - 1801 • The PA’s review of medical facts should be thorough, fair, and impartial and should not  
1802 exclude any relevant information in order to create a view favoring either the plaintiff or  
1803 the defendant. The ~~expert~~ **PA SERVING AS AN EXPERT WITNESS** should champion  
1804 what ~~he or she~~ **THE PA** believes to be the truth.
  - 1805 • A PA giving testimony does not attack performance that which falls within accepted  
1806 standards of practice or support obviously deficient practice.
  - 1807 • A PA offering an opinion should know what constitutes customary practice. Testimony  
1808 about innovation in medical practice should be identified as such.
  - 1809 • The PA should testify truthfully and consistently, recognizing his or her testimony may  
1810 be subject to peer review.
  - 1811 • The PA should not accept a contingency fee – compensation based on the outcome of a  
1812 case in which testimony is given – or derive personal, financial, or professional favor in  
1813 addition to compensation.

1813 **Introduction**

1814 A PA may serve as a witness in a legal proceeding in one of several capacities.<sup>1</sup>  
1815 These guidelines discuss serving as expert witness and giving opinions in professional  
1816 liability (medical malpractice) cases. Accompanying notes and references outline other

1817 roles a PA may have as a witness or consultant, preparation for testifying, legal terms,  
1818 strategies and tactics that may be encountered.

1819 It is the intent of the Academy to inform PAs about the duties PAs have, as health  
1820 care professionals, to society, the legal system, and the profession. These guidelines and  
1821 comments are not legal advice. PAs involved in legal matters are urged to obtain legal  
1822 advice from a qualified attorney.

1823 A PA may be called upon or directed to give an expert medical opinion in the  
1824 judicial system because knowledge about medicine and PA practice is generally  
1825 considered beyond the average judge or juror's experience. A patient who alleges injury  
1826 (plaintiff) and the judge or jury will need opinions about standards of medical care, if and  
1827 how a standard of care was met, and, if not, how falling below a standard caused injury to  
1828 the patient. The practitioner (defendant) may also need expert opinions and may serve as  
1829 an expert witness in his or her own behalf.

1830 The responsibility of providing a professional opinion as an expert witness should be  
1831 undertaken after careful self-evaluation and thorough preparation with an attorney. The  
1832 PA should have an understanding of medical, legal and ethical principles involved.<sup>2</sup>

1833 **Guideline 1: A PA serving as an expert witness should have current**  
1834 **experience and knowledge in the area(s) about which ~~he or she~~ THE PA is to**  
1835 **testify.<sup>3</sup>**

1836 A PA's knowledge and experience alone may not sufficiently satisfy an attorney  
1837 or qualify the PA to testify in court as an expert witness. Maturity, integrity, composure  
1838 and other personal characteristics should be evaluated with an attorney prior to offering  
1839 testimony. Prior testimony, income from testifying, potential conflicts of interest with, or  
1840 bias toward, other parties involved in the case may render a PA unsuitable as a witness.  
1841 If, after meeting with an attorney, the PA is unclear on issues about which ~~he or she~~ THE  
1842 PA will testify, feels uncomfortable offering an opinion, or has no opinion, voluntary  
1843 testimony should not be given.

1844 **Guideline 2: A ~~PA expert~~ PA SERVING AS AN EXPERT WITNESS must**  
1845 **objectively evaluate facts and provide an opinion. If no opinion can be**  
1846 **derived from available facts, this should be stated to the attorney. The PA's**  
1847 **review of medical facts should be thorough, fair, and impartial and should**  
1848 **not exclude any relevant information in order to create a view favoring either**  
1849 **the plaintiff or the defendant. The PA SERVING AS AN expert WITNESS**  
1850 **should champion what ~~he or she~~ THE PA believes to be the truth.**

1851 PAs serving as expert witnesses have an ethical responsibility to the profession.  
1852 The Guidelines for Ethical Conduct for the PA Profession admonishes a PA from  
1853 participating in an activity that will discredit or dishonor the profession. Providing an  
1854 expert opinion in a judicial process is never a trivial matter. There are risks to the witness,  
1855 profession, other parties, and society. Yet, AAPA Policy further asks PAs to expose  
1856 without fear or favor, any illegal or unethical conduct in the medical profession.  
1857 Participating in a judicial proceeding as an expert witness, like peer review, is a necessary  
1858 obligation of the profession and its members. Expert opinion may support or criticize a  
1859 colleague.

1860 This duty, to serve for the good of society and the courts, is a guiding principle.  
1861 This responsibility may override the concept that PAs should act, in these situations, as  
1862 advocates for a patient or serve only a patient's interest. Expert opinion may help or  
1863 hinder a patient's cause.



1864 **Guideline 3: It is incumbent upon a PA giving testimony in legal proceedings**  
1865 **that his or her testimony does not attack performance that falls within**  
1866 **accepted standards of practice or, conversely, support obviously deficient**  
1867 **practice. Since experts establish the standards of practice in a given case,**  
1868 **care should be exercised to ensure that such standards do not narrowly**  
1869 **reflect the experts' views to the exclusion of other acceptable choices.**

1870 An expert witness should recognize that there is uncertainty inherent in medical  
1871 practice. It is a dynamic and changing discipline based on concepts of probability rather  
1872 than on absolute certainty. Principles drawn from the experience of a number of patients  
1873 and providers are applied to individual patients with hope for success. Further, with  
1874 technologically advanced medical care, both benefits and risks are likely to be increased.  
1875 Risks of complication in the practice of technical specialties can be frequent and/or  
1876 severe. In providing expert testimony, a PA should have in mind a clear distinction  
1877 between the occurrence of unavoidable and/or severe complications which do not  
1878 represent malpractice (good medical care, but a bad outcome), and the occurrence due to  
1879 negligence<sup>4</sup> (poor medical care that contributes to or causes a bad outcome).

1880 Testimony is usually given concerning customary or standard practice. Innovation  
1881 in medical practice is sometimes considered in a legal proceeding. An innovation may or  
1882 may not fall outside of the standard of care. Many advances in medical practice rely on  
1883 innovation.

1884 **Guideline 4: A PA offering an opinion should know what constitutes**  
1885 **customary practice. Testimony about innovation in medical practice should**  
1886 **be identified as such.**

1887 A PA may offer an expert opinion several times in one legal proceeding or in  
1888 several separate proceedings. Expert testimony offered by the PA in previous cases and  
1889 proceedings is often reviewed and compared by attorneys and other experts. All  
1890 testimony should be truthful and consistent.

1891 **Guideline 5: The PA should testify truthfully and consistently, recognizing**  
1892 **his or her testimony may be subject to peer review.**

1893 Custom and rules governing compensation for legal witnesses vary. The PA  
1894 should be fairly compensated for time spent preparing, appearing and testifying as an  
1895 expert witness.

1896 **Guideline 6: The PA should not accept a contingency fee — compensation**  
1897 **based on the outcome of a case in which testimony is given — or derive**  
1898 **personal, financial, or professional favor in addition to compensation.**

#### 1899 Summary of Academy

#### 1900 Guidelines for the PA Serving as an Expert Witness

1901 The PA should have current experience and ongoing knowledge in the areas of  
1902 clinical practice about which ~~he or she~~ **THE PA** is testifying.

1903 The PA should objectively evaluate the facts and provide an opinion. The PA's  
1904 review of medical facts should be thorough, fair and impartial and should not exclude any  
1905 relevant information in order to create a view favoring either the plaintiff or the  
1906 defendant. The **PA SERVING AS AN** expert **WITNESS** should champion what ~~he or she~~  
1907 **THE PA** believes to be the truth, not the cause of one party in a dispute.

1908  
1909 **2018-A-23 – Adopted on Consent Agenda**  
1910

1911 Amend policy HX-3700.3.2 entitled “Licensure Eligibility for PAs Trained Abroad” as  
1912 follows:

1913  
1914 **Only sections of the policy paper with proposed amendments are presented.**  
1915 **The entire paper can be found in the policy manual.**

1916  
1917 **Licensure Eligibility for PAs Trained Abroad**  
1918 (Adopted 2004, amended 2009, reaffirmed 2014)

1919  
1920 **Only sections of the policy paper with proposed amendments are presented here.**  
1921 **The entire paper can be found in the policy manual.**

1922  
1923 **Licensure Requirements for PAs Trained Abroad**

1924 AAPA believes that the following represents a framework for PAs trained abroad  
1925 who wish to become licensed in the United States.

- 1926 • A visa screening or credentialing organization, such as the Commission on  
1927 Graduates of Foreign Nursing Schools or other recognized entity, should  
1928 verify the PA education, PA licensure, experience, and English proficiency of  
1929 non-U.S. citizen PAs trained abroad, as is currently required by federal law  
1930 for international health care workers, entering the United States.
- 1931 • PAs trained abroad should apply for acceptance at an ARC-PA accredited  
1932 entry level PA program. They should present evidence of their prior education  
1933 and experience and request credit for coursework completed.
- 1934 • Entry level PA programs should consider applications from PAs trained  
1935 abroad and offer advanced standing, if appropriate, to those who meet their  
1936 admission criteria.
- 1937 • The education for these individuals in U.S. PA programs is envisioned to  
1938 include four components:
  - 1939 o Credit for some of the coursework and/or rotations done in their own  
1940 country and/or in the United States;
  - 1941 o Didactic coursework in those areas for which they did not receive  
1942 advanced standing;
  - 1943 o Mandatory didactic coursework about physician-PA role and team  
1944 practice and standards of care in the United States;
  - 1945 o Clinical rotations.
- 1946 • Only those programs with the interest and resources necessary to handle this  
1947 complement of students should do so. Those that lack the faculty or clinical  
1948 rotations or that would face state or institutional barriers would not have to  
1949 offer this educational experience to PAs trained outside the United States.

1950 In summary, non U.S. citizen PAs trained abroad who wish to enter the U.S. for  
1951 the purposes of working as PAs should have their education, experience, license, and  
1952 English proficiency verified by CGFNS or another approved visa screening organization.  
1953 They would submit their certification with their visa applications. If granted visas, they  
1954 would come to the U.S., where they would apply for admission to an accredited PA  
1955 program. Programs that choose to accept these individuals, including American citizens  
1956 who have obtained PA training abroad, can apply their own admission criteria and may

1957 consider granting advanced standing to the limits established by the program's  
1958 sponsoring institution. After admission and graduation from an accredited PA program,  
1959 these individuals would be eligible to sit for the PANCE. Passage of the PANCE would  
1960 make them eligible for state licensure.

1961 This system is similar to the one that exists for physicians (see Appendix 2) in  
1962 that it requires additional supervised education in the U.S. Completion of this education  
1963 would be followed by a requirement to take the same NCCPA examination that is given  
1964 to U.S. graduates prior to licensure.

1965 The proposal described above does not necessarily require every PA trained  
1966 abroad to repeat ~~his or her~~ **THEIR** entire education after arriving in this country. AAPA  
1967 believes it is appropriate to evaluate separately each individual who has received PA  
1968 education outside the U.S. and to give credit for coursework and/or rotations completed  
1969 in their own country or in the U.S.

1970 AAPA acknowledges that there are cultural and educational differences among  
1971 the countries of the world, and that the knowledge needed to practice according to the  
1972 standards of care of each country can vary substantially. That is why the Academy  
1973 recommends that PAs trained abroad seeking licensure be required to have additional  
1974 supervised clinical education at an accredited entry-level PA program and be taught more  
1975 about the PA role as part of physician-led teams in the U.S. health care system.

1976 The Academy hopes, with the adoption of this document, that other countries will  
1977 adopt similar practice requirements for American PAs who wish to work abroad. While  
1978 American PAs may have much to contribute, it is essential to respect cultural differences  
1979 and values and to be knowledgeable about health system norms, allocation of resources,  
1980 and treatment of conditions common to the population before working in another country.

#### 1981 **Appendix 1. Immigration Procedures for Foreign Health Care Workers**

1982 Immigration law requires that individuals wishing to enter the United States on  
1983 either a temporary or permanent basis must apply to the U.S. State Department for a visa.  
1984 There are two major categories of visas: non-immigrant and immigrant. Non-immigrant  
1985 visas are given to individuals who wish to come to the U.S. on a temporary basis and for  
1986 a specific purpose. There are approximately 60 different non-immigrant visa  
1987 classifications, in areas such as business, education, pleasure, and temporary work.  
1988 Immigrant visas are given to individuals who intend to live and work permanently in the  
1989 U.S. These visas are either family- or employment-based.

1990 The law specifies the documentation that must accompany visa applications. For  
1991 example, individuals applying for H-1B visas (temporary work in a specialty occupation  
1992 such as law or engineering) must submit evidence regarding education or experience and  
1993 qualifications. In some cases, a permanent or temporary state license to practice must be  
1994 obtained prior to approval of the visa application.

1995 There are specific provisions in the law regarding foreign physicians and nurses.  
1996 In 1996, Congress amended the Immigration and Nationality Act to add, among other  
1997 things, provisions related to other foreign health care workers. The 1996 amendments  
1998 require all immigrants and non-immigrants coming to the U.S. as health care workers to  
1999 be screened and certified by the Commission on Graduates of Foreign Nursing Schools  
2000 (CGFNS) or an equivalent independent credentialing organization approved by the U.S.  
2001 Attorney General. Health care workers are defined as physical and occupational  
2002 therapists, medical technicians and clinical laboratory scientists, speech language  
2003 pathologists and audiologists, and PAs.

2004 The screening organization must verify that the alien’s education, training,  
2005 license, and experience are comparable to those required for an American health care  
2006 worker of the same type; that they are authentic, and, in the case of a license,  
2007 unencumbered. The foreign health care worker must also have an appropriate level of  
2008 proficiency in written and spoken English. If the majority of states licensing the  
2009 profession in which the alien intends to work recognize a test that predicts an applicant’s  
2010 success on the profession’s licensing or certification examination, then the alien must  
2011 have passed that test.

2012 Anyone who meets these criteria is given a certificate that becomes part of ~~his or~~  
2013 ~~her~~ **THE FOREIGN HEALTH CARE WORKER’S** visa application.

2014  
2015 **2018-B-01 – Adopted as Amended**

2016  
2017 Amend policy HP-3100.1.3 as follows:

2018  
2019 **AAPA DISCOURAGES THE USE OF TERMS SUCH AS MIDDLELEVEL PROVIDERS,**  
2020 **PHYSICIAN EXTENDERS, ALLIED HEALTH PROFESSIONALS OR ANY**  
2021 **OTHER TERMS THAT DEVALUE PAS’ CONTRIBUTION TO HEALTHCARE.**

2022  
2023 **2018-B-02 – Adopted as Amended**

2024  
2025 ~~AAPA believes the terms “advanced practice provider” and “advanced practice clinician”~~  
2026 ~~should only be representative of REFER ONLY TO ARE APPROPRIATE~~  
2027 ~~TERMINOLOGY TO USE TO DESCRIBE COLLECTIVE WORK OF PAs and APRNs~~  
2028 ~~in a healthcare system or practice.~~

2029  
2030 **AAPA BELIEVES WHENEVER POSSIBLE, PAS SHOULD BE REFERRED TO AS**  
2031 **PAS. AAPA RECOGNIZES ENTITIES MAY USE THE TERMS “ADVANCED**  
2032 **PRACTICE PROVIDERS” OR “ADVANCED PRACTICE CLINICIANS” WHICH**  
2033 **SHOULD ONLY REFER TO PAS AND APRNS.**

2034  
2035 **2018-B-03 – Adopted**

2036  
2037 Amend policy HP-3100.1.3.1 as follows:

2038  
2039 PAs should ~~utilize, and~~ encourage employers (~~e.g., hospitals, HMO’s, clinics~~), third party  
2040 payers, educators, researchers, and the government to utilize the term “PA” OR  
2041 “physician assistant” ~~or “PA”~~ to **INCREASE TRANSPARENCY AND VISIBILITY**  
2042 **unique position** of PAs ~~in~~ **THROUGHOUT** the healthcare system.

2043  
2044 **2018-B-04 – Adopted**

2045  
2046 Amend policy HP-3200.3.5 as follows:

2047  
2048 AAPA shall continue to educate and serve as a resource to students, programs, and  
2049 graduate PAs on issues concerning reimbursement for ~~physician~~ **MEDICAL** services  
2050 provided by PAs.

2051

2052 **2018-B-05 – Adopted as Amended**

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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,~~ ~~†~~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**

2100 OF EMPLOYMENT. In states where federal state requirements do not conflict; federal  
2101 PAs may hold state licenses.

2102  
2103 Any federalLY EMPLOYED PA SHOULD BE ABLE TO may opt to hold a state  
2104 license.

2105

2106 **2018-B-07 – Adopted on Consent Agenda**

2107

2108 Amend policy HP-3600.1.5 as follows:

2109

2110 AAPA believes that services provided by PAS physician-PA teams should be counted  
2111 when federal and state governments determine the primary healthcare service needs of  
2112 medically underserved and health professional shortage areas. Recognition of PA  
2113 physician-PA team productivity should not be done in such a way as to decrease patient  
2114 access to care.

2115

2116 **2018-B-08 – Adopted on Consent Agenda**

2117

2118 Amend policy HX-4500.3 as follows:

2119

2120 AAPA believes that TO ENSURE ACCOUNTABILITY FOR THE PROVISION OF  
2121 CARE PROVIDED BY EACH MEMBER OF THE HEALTHCARE TEAM, electronic  
2122 health record (EHR) systems, computerized provider order entry (CPOE) systems,  
2123 reimbursement and claims systems, and other health information technology systems  
2124 should individually recognize and APPROPRIATELY ATTRIBUTE PA-PROVIDED  
2125 PATIENT CARE DATA TO INDIVIDUAL PAS. support the optimal utilization of PAs,  
2126 and, when appropriate, provide attribution to PAs.

2127

2128 Health information technology systems should be designed, developed, and implemented  
2129 with appropriate PA input in a manner that benefits patients, the physician-PA team PAS,  
2130 and the healthcare system TEAM by improving quality, TRANSPARENCY AND  
2131 ACCURACY. encouraging patient-centered care, and reducing costs.

2132

2133 **2018-B-09 – Adopted**

2134

2135 Amend policy HX-4600.1.3 as follows:

2136

2137 AAPA BELIEVES Ccoverage for the treatment of mental health and substance use  
2138 disorders should be available, nondiscriminatory and covered at the same benefit level as  
2139 other medical care.

2140

2141 AAPA BELIEVES Rreimbursement for PAs providing mental health and substance use  
2142 disorder care should be provided in the same manner as other MEDICAL physician  
2143 services provided by PAs.

2144

2145 AAPA BELIEVES NO INSURANCE COMPANY, THIRD-PARTY PAYER OR  
2146 HEALTH SERVICES ORGANIZATION SHALL IMPOSE A PRACTICE,



2147 **EDUCATION OR COLLABORATION REQUIREMENT THAT IS INCONSISTENT**  
2148 **WITH OR MORE RESTRICTIVE THAN EXISTING PA STATE LAW.**  
2149

2150 **2018-B-10 – Adopted on Consent Agenda**  
2151

2152 Amend policy HP-3300.2.10 entitled “Use of Medical Interpreters for Patients with  
2153 Limited English Proficiency” as follows:  
2154

2155 **Use of Medical Interpreters for Patients with Limited English Proficiency**

2156 *(Adopted 2003, reaffirmed 2008, 2013)*  
2157

2158 **Executive Summary of Policy Contained in this Paper**

2159 Summaries will lack rationale and background information, and may lose nuance of  
2160 policy. You are highly encouraged to read the entire paper.  
2161

- 2162 • **PAS HAVE AN ETHICAL AND LEGAL OBLIGATION TO USE**  
2163 **APPROPRIATELY TRAINED MEDICAL INTERPRETERS FOR THEIR**  
2164 **PATIENTS WITH LIMITED ABILITY TO SPEAK OR UNDERSTAND**  
2165 **ENGLISH.**  
2166

2167 PAs provide vitally important services to patients. The effectiveness of the care  
2168 delivered by PAs depends heavily on the establishment of a PA-patient relationship based  
2169 on empathy, confidence, trust, and the free flow of communication. The exchange of  
2170 information can be difficult when the two parties involved speak different languages.

2171 Language difficulties have been identified as one of the leading barriers to  
2172 obtaining effective health care in the United States(1). The number of people in the  
2173 United States with limited English proficiency (LEP) is increasing. **Recent THE 2016**  
2174  **census data showS that 44 65.5 million Americans INDIVIDUALS** speak a language  
2175 other than English at home(2).

2176 Based on Title VI of the 1964 Civil Rights Act, which promises equal access to  
2177 federally assisted programs and activities to everyone in the United States, the Office of  
2178 Civil Rights (OCR) of the Department of Health and Human Services issued a policy  
2179 guidance **in August 2000** that affects PAs and other health care providers(3) **(see**  
2180 **<http://www.hhs.gov/ocr/lep/guide.html>** the document clarifies a requirement that  
2181 recipients of federal assistance provide translation services at no cost to people whose  
2182 ability to read, speak, or understand English is limited. This means that health care  
2183 providers who accept Medicare and Medicaid payment for their services to LEP patients  
2184 should provide them with effective language assistance. The goal is to make sure that all  
2185 patients receive quality medical care, even in circumstances where a health care  
2186 professional and a patient speak different languages.

2187 It is a challenge to determine how to overcome the communication barrier that  
2188 could leave patients without adequate or appropriate medical attention. Because the  
2189 diversity of health care providers does not match, either ethnically or geographically, the  
2190 diversity of the patient population, the use of qualified medical interpreters is a critical  
2191 part of the solution.

2192 Competent medical interpretation requires a specialized set of skills that extends  
2193 beyond the knowledge of two languages. The use of an interpreter who lacks the  
2194 competency to accurately convey technical information can lead to misdiagnoses and



2195 inappropriate treatments(4). It also places health care providers at greatly increased legal  
2196 risk. There are significant drawbacks to using a patient’s friends or family, especially  
2197 children, as interpreters. These include the likelihood of inaccurate translations,  
2198 omissions, additions, substitutions, volunteered answers, personal opinions, and other  
2199 problems. The use of untrained interpreters also increases the risk of breaching patient  
2200 privacy and confidentiality requirements(5).

2201 Trained, professional medical interpreters are held to high standards by codes of  
2202 ethics to which they must adhere(6). This helps preserve the confidentiality of patient  
2203 information. In addition, professional interpreters should be able to provide not only  
2204 accurate translations, but also culturally and socially informed explanations.

2205 The Office of Civil Rights requires health care providers with publicly-assisted  
2206 LEP patients to have reasonable policies and procedures in place(3). This may include  
2207 hiring bilingual staff who are trained and competent interpreters, hiring staff interpreters,  
2208 contracting with an outside interpreter service, arranging for the services of voluntary  
2209 community interpreters, and using a telephone language interpreter service. Patients may  
2210 be referred to nearby facilities that have translators, but providers are obligated to follow  
2211 up to make sure that appropriate care is given. Written materials that are routinely  
2212 provided to patients, such as consent forms and medication instructions, must be  
2213 translated. LEP patients must also be notified of their right to free language assistance.  
2214 OCR says that friends, family, and minor children may be used as interpreters only after  
2215 patients have been informed of their right to free translation services and have declined  
2216 their use.

2217 OCR requires that covered providers ensure that they are using competent  
2218 interpreters. Interpreters may hold formal certification. Alternatively, they may prove  
2219 their competence through demonstrated proficiency in both English and the other  
2220 language, orientation and training that includes the skills and ethics of interpreting,  
2221 fundamental knowledge in both languages of any specialized terms or concepts,  
2222 sensitivity to the LEP patient’s culture, and the ability to convey information in both  
2223 languages accurately.

2224 The requirements of assuring interpreter competency and underwriting the cost of  
2225 providing interpreter services are two stumbling blocks to full and effective  
2226 implementation of the OCR guidance. Nevertheless, compliance is required by all  
2227 covered providers. OCR investigates all complaints, reports, or other information that  
2228 allege or indicate noncompliance with Title VI of the Civil Rights Act. OCR will provide  
2229 technical assistance, consultation, and reasonable timetables in such cases, but failure to  
2230 resolve the problem could result in exclusion from the Medicare or Medicaid program,  
2231 referral to the Department of Justice for enforcement proceedings, or other actions.

2232 The Guidelines for Ethical Conduct for the PA Profession are clear in their  
2233 emphasis on PA-patient relationships; respect for dignity, confidentiality, and diversity;  
2234 non-discrimination; informed consent; and other principles that come into play when  
2235 treating LEP patients. PAs thus have an ethical and legal obligation to use appropriately  
2236 trained medical interpreters for their patients with limited ability to speak or understand  
2237 English.

## 2238 **SUMMARY**

2239 AN INCREASING PROPORTION OF THE POPULATION OF THE UNITED  
2240 STATES IS NOT FLUENT IN ENGLISH. WHEN IT COMES TO PROVIDING  
2241 HEALTH CARE, IT IS APPROPRIATE TO USE MEDICAL INTERPRETERS THAT  
2242 ARE NOT ONLY FLUENT IN THE LANGUAGE, BUT ALSO CULTURALLY

2243 AWARE IN ORDER TO PROVIDE THE MOST ACCURATE INTERPRETATION  
2244 POSSIBLE. THIS IS IMPORTANT FROM AN ETHICAL STANDPOINT BUT ALSO  
2245 A MEDICOLEGAL ONE, AND MANDATED BY FEDERAL REGULATIONS.

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2263 [RECIPIENTS-TITLE-VI/INDEX.HTML](https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html). ACCESSED ON MARCH 24, 2018.
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2275  
2276 **2018-B-11 – Adopted as Amended**

2277  
2278 APA supports and encourages awareness and recognition of professional burnout in all  
2279 healthcare providers and education on the prevention of burnout. APA supports and  
2280 encourages all healthcare providers to engage in ~~self care as part of burnout prevention.~~  
2281 **A COMPREHENSIVE MULTI-PRONGED STRATEGY FOR PREVENTION OF**  
2282 **PROFESSIONAL BURNOUT.**

2283  
2284 **2018-B-12 – Adopted on Consent Agenda**

2285  
2286 APA opposes any mandatory policy, regulation or restriction in state or federal law that  
2287 limits the number of PAs and physicians that can form collaborative relationships.  
2288 APA believes that the number of PA and physician collaborative relationships should  
2289 be determined at the practice level.

2290

2291 **2018-B-13 – Adopted**

2292

2293 Amend policy HP-3800.2.2 entitled “Acknowledging and Apologizing for Adverse  
2294 Outcomes” as follows:

2295

2296

**Acknowledging and Apologizing for Adverse Outcomes**

2297

(Adopted 2007, reaffirmed 2012, amended 2013)

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**Executive Summary of Policy Contained in this Paper**

2300

Summaries will lack rationale and background information, and may lose nuance of  
2301 policy. You are highly encouraged to read the entire paper.

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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.

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- 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.

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**Disclosing Errors**

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IMPROVING HEALTHCARE QUALITY AND REDUCING PREVENTABLE  
ADVERSE EVENTS IN CARE DELIVERY CONTINUE TO BE A TOP PRIORITY  
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ERROR HAS SEEN SIGNIFICANT ADVANCEMENT.

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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 (23). Further, preventable harm from care  
delivery impacts not only patients, but families, caregivers, staff and communities (23).

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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 (23). 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

2339 organizational response (i.e. initiate root cause analysis and crisis management team)  
2340 (23).

2341 **The Patient and Family**

2342 The patient and family must be the priority of the health care organization and the  
2343 provider before, during and after an adverse event (23). Disclosing medical errors  
2344 respects patient autonomy and truth-telling, is desired by patients, and has been endorsed  
2345 by many ethicists and professional organizations (4).<sup>4</sup> According to the AAPA'S  
2346 "Guidelines for Ethical Conduct for the PA Profession," PAs "should disclose errors to  
2347 patients if such information is significant to the patient's interests and well-being. As  
2348 disclosure science in health care continues to develop, much of the data generated  
2349 highlights the fundamental importance of openly admitting error (45). A number of  
2350 studies suggest that both the public and health care professionals generally agree that  
2351 medical errors causing harm should be disclosed to the patient, an apology rendered, and,  
2352 IN SOME CASES, fair compensation be negotiated. This process has demonstrated a  
2353 reduction in litigation costs and has been widely adopted by health systems both  
2354 academic and federal (56).

2355 **The Frontline Staff**

2356 Health care staff can become the "second victims" of adverse events (23). This  
2357 may occur secondary to blaming behaviors, damage to personal or professional  
2358 reputation, and unresolved feelings of sorrow and loss (23). Organizations with an  
2359 existing crisis management plan, a shared process of root cause analysis and culture of  
2360 inclusion promote patient-centered quality and safety (23).

2361 **The Organizational Response**

2362 The culture of safe and high-quality health care begins with the organizational  
2363 leader, who proactively develops a crisis management plan and assumes shared  
2364 responsibility when adverse events take place (23). Following an adverse event, it is  
2365 critical for leaders to include all stakeholders in the root cause analysis (23). This process  
2366 enhances communication, promotes healing and ensures learning takes place (23). Most  
2367 importantly, leadership must ensure that the patient and family are clearly informed  
2368 throughout the process of the investigation (23).

2369 **Policy and Legislation**

2370 To counter the perceived risk of increased liability, a number MAJORITY of  
2371 states have adopted ~~or are considering~~ apology laws that exempt ALL OR SOME  
2372 expressions of regret, sympathy, or compassion from being considered as admissions of  
2373 liability in medical malpractice lawsuits (7, 8).<sup>16</sup> ~~Federal legislation has also been drafted  
2374 that promotes medical error reporting, disclosure to patients, apology, and, in cases when  
2375 the standard of care is not met, offers of compensation. This legislation is based on the  
2376 principles of~~

2377 The Sorry Works! Coalition, AN ADVOCATE FOR LEGISLATIVE, POLICY  
2378 AND CULTURAL CHANGE ~~which~~ believes that full disclosure addresses the root cause  
2379 of the medical malpractice crisis better than any other approach currently under  
2380 consideration (9). THE COALITION TEACHES HEALTHCARE, INSURANCE, AND  
2381 LEGAL PROFESSIONALS HOW TO STAY CONNECTED WITH PATIENTS AND  
2382 FAMILIES AFTER ADVERSE MEDICAL EVENTS WITH A THREE-STEP  
2383 PROCESS OF EMPATHY, REVIEW, AND RESOLUTION (10). ~~According to the  
2384 coalition, Sorry Works! restores the provider-patient relationship and improves the  
2385 communication and trust between all parties, thus reducing the filing of non-meritorious  
2386 claims and saving on legal expenses.~~<sup>13</sup>

2387 While the coalition believes that legislative action or mandates are not necessary  
2388 preconditions for implementation of a full disclosure program, **THEY RECOGNIZE**  
2389 **THAT SOME others** prefer the security provided by legislation that reduces liability.

2390 **Conclusion**

2391 In the spirit of patient-centered care, AAPA believes that patients deserve  
2392 complete and honest explanations of adverse outcomes and apologies for medical  
2393 mistakes. AAPA also supports not only the current science around disclosure and  
2394 apology during care delivery, but also encourages PAs to be active participants in local  
2395 disclosure programs.

2396 **References**

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2423 **2018-B-14 – Adopted as Amended**

2424

2425 The AAPA HOD requests that the Board of Directors contract with **APPROPRIATE**  
2426 independent ~~marketing/PR~~ **CONSULTING/RESEARCH** firmS to investigate  
2427 **STATE/FEDERAL, FINANCIAL, POLITICAL, BRANDING ASPECTS, AND**  
2428 **ALTERNATIVES TO** the creation of a new professional title for physician assistants that  
2429 accurately reflects **AAPA PROFESSIONAL PRACTICE POLICIES** ~~these provider's~~  
2430 ~~present and future utilization and practice abilities~~, reporting the results to the 2019 HOD.

2431

2432 **2018-B-15 – Rejected**

2433



2434 Amend policy HP-3500.3.4 entitled “Guidelines for State Regulation of PAs” to add  
2435 language more clearly emphasizing that Optimal Team Practice (OTP) is not intended to  
2436 establish the independent practice of medicine by PAs thereby addressing the concerns of  
2437 organized medicine as follows:  
2438

2439 **Guidelines for State Regulation of PAs**

2440 (Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011, 2013,  
2441 2016, 2017)  
2442

2443 **Executive Summary of Policy Contained in this Paper**

2444 Summaries will lack rationale and background information and may lose  
2445 nuance of policy. You are highly encouraged to read the entire paper.  
2446

- 2447 • AAPA believes inclusion of PAs in state law and delegation of  
2448 authority to regulate their practice to a state agency serves to both  
2449 protect the public from incompetent performance by unqualified  
2450 medical providers and to define the role of PAs in the healthcare  
2451 system.
- 2452 • AAPA, while recognizing the differences in political and healthcare  
2453 climates in each state, endorses standardization of PA regulation to  
2454 enhance appropriate and flexible professional practice.  
2455

2456 **Introduction**

2457 Recognition of PAs as medical providers led to the development of state laws  
2458 and regulations to govern their practice. Inclusion of PAs in state law and delegation of  
2459 authority to regulate their practice to a state regulatory body serves two main purposes:  
2460 (1) to protect the public from incompetent performance by unqualified medical  
2461 providers, and (2) to define the role of PAs in the healthcare system. Since the inception  
2462 of the profession, dramatic changes have occurred in the way states have dealt with PA  
2463 practice. In concert with these developments has been the creation of a body of  
2464 knowledge on legislative and regulatory control of PA practice. It is now possible to  
2465 state which specific concepts in PA statutes and regulations enable appropriate practice  
2466 by PAs as medical providers while protecting the public health and safety.

2467 What follows are general guidelines on state governmental control of PA  
2468 practice. The AAPA recognizes that the uniqueness of each state’s political and  
2469 healthcare climate will require modification of some provisions. However,  
2470 standardization of PA regulation will enhance appropriate and flexible PA practice  
2471 nationwide. This document does not contain specific language for direct incorporation  
2472 into statutes or regulations, nor is it inclusive of all concepts generally contained in state  
2473 practice acts or regulations. Rather, its intent is to clarify key elements of regulation and  
2474 to assist states as they pursue improvements in state governmental control of PAs. To  
2475 see how these concepts can be adapted into legislative language, please consult the  
2476 AAPA’s model state legislation for PAs.

2477 **Definition of PA**

2478 The legal definition of PA should mean a healthcare professional who  
2479 meets the qualifications for licensure and is licensed to practice medicine- **IN**  
2480 **COLLABORATION WITH PHYSICIANS.**



2481 **Qualifications for Licensure**

2482 Qualifications for licensure should include graduation from an accredited PA  
2483 program and passage of the PA National Certifying Examination (PANCE)  
2484 administered by the National Commission on Certification of PAs (NCCPA).

2485 PA programs were originally accredited by the American Medical  
2486 Association's Council on Medical Education (1972-1976), which turned over  
2487 its responsibilities to the AMA's Committee on Allied Health Education and  
2488 Accreditation (CAHEA) in 1976. CAHEA was replaced in 1994 by the  
2489 Commission on Accreditation of Allied Health Education Programs  
2490 (CAAHEP). On January 1, 2001, the Accreditation Review Commission on  
2491 Education for the PA (ARC-PA), which had been part of both the CAHEA and  
2492 CAAHEP systems, became a freestanding accrediting body and the only  
2493 national accrediting agency for PA programs.

2494 Because the law must recognize the eligibility for licensure of PAs that  
2495 graduated from a PA program accredited by the earlier agencies, the law should  
2496 specify individuals who have graduated from a PA program accredited by the  
2497 ARC-PA or one of its predecessor agencies, CAHEA or CAAHEP.

2498 The qualifications should specifically include passage of the national  
2499 certifying examination administered by the NCCPA. No other certifying body or  
2500 examination should be considered equivalent to the NCCPA or the PANCE.

2501 The NCCPA, since 1986, has allowed only graduates of accredited PA  
2502 programs to take its examination. However, between 1973-1986, the exam was open  
2503 to individuals who had practiced as PAs in primary care for four of the previous five  
2504 years, as documented by their supervising physician. Nurse practitioners and graduates  
2505 of unaccredited PA programs were also eligible for the exam. An exceptions clause  
2506 should be included to allow these individuals to be eligible for licensure.

2507 **Licensure**

2508 When a regulatory **board AGENCY** has verified a PA's qualifications, it should  
2509 issue a license to the applicant. Although, in the past, registration and certification have  
2510 been used as the regulatory term for PAs, licensure is now the designation and system  
2511 used in all states. This is appropriate because licensure is the most stringent form of  
2512 regulation. Practice without a license is subject to severe penalties. Licensure both  
2513 protects the public from unqualified providers and utilizes a regulatory term that is easily  
2514 understood by healthcare consumers.

2515 Applicants who meet the qualifications for licensure should be issued a license.  
2516 States should not require employment or identification of a supervising, collaborating,  
2517 or other specific relationship with a physician(s) as a condition or component of  
2518 licensure. A category of inactive licensure should be available for PAs who are not  
2519 currently in active practice in the state. If issuance of a full license requires approval at  
2520 a scheduled meeting of the regulatory agency, a temporary license should be available  
2521 to applicants who meet all licensure requirements but are awaiting the next meeting of  
2522 the board.

2523 If the **board REGULATORY AGENCY** uses continuous clinical practice as  
2524 a requirement for licensure, it should recognize the nature of PA practice when  
2525 determining requirements for PAs who are reentering clinical practice (defined as a  
2526 return to clinical practice as a PA following an extended period of clinical inactivity  
2527 unrelated to disciplinary action or impairment issues). Each PA reentering clinical  
2528 practice will have unique circumstances. Therefore, the board should be authorized

2529 to customize requirements imposed on PAs reentering clinical practice. Acceptable  
2530 options could include requiring current certification, development of a personalized  
2531 re-entry plan, or temporary authorization to practice for a specified period. Although  
2532 it has not yet been determined conclusively that absence from clinical practice is  
2533 associated with a decrease in competence, there is concern that this may be the case.  
2534 Reentry requirements should not be imposed for an absence from clinical practice  
2535 that is less than two years in duration.

2536 Because of the high level of responsibility of PAs, it is reasonable for  
2537 licensing agencies to conduct criminal background checks on individuals who apply  
2538 for licensure as PAs. **Licensing REGULATORY** agencies should have the discretion  
2539 to grant or deny licensure based on the findings of background checks and  
2540 information provided by applicants.

#### 2541 **Optimal Team Practice**

2542 Since the inception of the profession, PAs have embraced team-based patient-  
2543 centered practice and continue to do so. Because both PAs and physicians are trained in  
2544 the medical model and use similar clinical reasoning, PA/physician teams are especially  
2545 effective and valued.

2546 Optimal team practice ~~occurs when~~ **IS DEFINED AS PAs, AS PART OF A**  
2547 **HEALTHCARE TEAM, have the ability to collaborate COLLABORATING AND**  
2548 ~~consult~~ **CONSULTING WITH** physicianS or other qualified medical professionals, as  
2549 indicated by the patient’s condition and the standard of care, and in accordance with  
2550 the PA’s training, experience, and current competencies.

2551 The evolving medical practice environment requires flexibility in the  
2552 composition of teams and the roles of team members to meet the diverse needs of  
2553 patients. Therefore, the manner in which PAs and physicians **work PRACTICE**  
2554 together ~~should be~~ **IS** determined at the practice level.

2555 The PA/physician team model continues to be relevant, applicable and patient-  
2556 centered, ~~the degree of collaboration of the practicing PA~~ **THE DETAILS OF THE**  
2557 **PRACTICE RELATIONSHIP BETWEEN A PHYSICIAN AND A PA** should be  
2558 determined at the practice level in accordance with the practice type and the experience  
2559 and competencies of the ~~practicing~~ PA. State law should not ~~require a specific~~  
2560 ~~relationship between a PA, and physician, or any other entity~~ **MANDATE SPECIFIC**  
2561 **DETAILS OF THE PRACTICE OF THE PA** in order for a PA to practice to the full  
2562 extent of their education, training and experience. ~~Such requirements diminish~~  
2563 **ALLOWING SITE-SPECIFIC FLEXIBILITY PROMOTES TEAM PRACTICE,**  
2564 **INCREASES PATIENT ACCESS TO CARE, AND IMPROVES PATIENT SAFETY.**  
2565 ~~and therefore limit patient access to care, without improving patient safety. In addition,~~  
2566 ~~such requirements put all providers involved at risk of disciplinary action for reasons~~  
2567 ~~unrelated to patient care or outcomes. Like every clinical provider,~~ PAs are responsible  
2568 for the care they provide. Nothing in the law should require or imply that a physician is  
2569 responsible or liable for care provided by a PA, unless the PA is acting on the specific  
2570 instructions of the physician.

2571 Optimal team practice is applicable to all PAs, regardless of specialty or  
2572 experience.

2573 Whether a PA is early career, changing specialty or simply encountering a  
2574 condition with which they are unfamiliar, the PA is responsible for seeking consultation  
2575 as necessary to assure that the patient’s treatment is consistent with the standard of care.

2576 Notwithstanding the above provisions, these guidelines recognize that  
2577 medicine is rapidly changing. A modified model may be better for some states and  
2578 they should therefore feel free to craft alternative provisions.

2579 **PA Practice Ownership and Employment**

2580 In the early days of the profession the PA was commonly the employee of  
2581 the physician. In current systems physicians and PAs may be employees of the same  
2582 hospital, health system, or large practice. In some situations, the PA may be part or  
2583 sole owner of a practice. PA practice owners may be the employers of physicians.

2584 To allow for flexibility and creativity in tailoring healthcare systems that meet  
2585 the needs of specific patient populations, a variety of practice ownership and  
2586 employer-employee relationships should be available to physicians and to PAs. The  
2587 PA-physician relationship is built on trust, respect, and appreciation of the unique role  
2588 of each team member. No licensee should allow an employment arrangement to  
2589 interfere with sound clinical judgment or to diminish or influence his/her ethical  
2590 obligations to patients. State law provisions should authorize the regulatory authority  
2591 to discipline a physician or a PA who allows employment arrangements to exert  
2592 undue influence on sound clinical judgment or on their professional role and patient  
2593 obligations.

2594 **Disasters, Emergency Field Response and Volunteering**

2595 PAs should be allowed to provide medical care in disaster and emergency  
2596 situations.

2597 This may require the state to adopt language that permits PAs to respond to  
2598 medical emergencies that occur outside the place of employment. This exemption  
2599 should extend to PAs who are licensed in other states or who are federal employees.  
2600 PAs should be granted Good Samaritan immunity to the same extent that it is  
2601 available to other health professionals.

2602 PAs who are volunteering without compensation or remuneration should be  
2603 permitted to provide medical care as indicated by the patient's condition and the  
2604 standard of care, and in accordance with the PA's education, training, and  
2605 experience. State law should not require a specific relationship between a PA  
2606 physician, or any other entity for a PA to volunteer.

2607 **Scope of Practice**

2608 State law should permit PA practice in all specialties and settings. In general,  
2609 PAs should be permitted to provide any **legal** medical service that is within the PA's  
2610 education, training and experience. Medical services provided by PAs may include but  
2611 are not limited to ordering, performing and interpreting diagnostic studies, ordering and  
2612 performing therapeutic procedures, formulating diagnoses, providing patient education  
2613 on health promotion and disease prevention, providing treatment and prescribing  
2614 medical orders for treatment. This includes the ordering, prescribing, dispensing,  
2615 administration and procurement of drugs and medical devices. PA education includes  
2616 extensive training in pharmacology and clinical pharmacotherapeutics.

2617 Additional training, education or testing should not be required as a prerequisite  
2618 to PA prescriptive authority. PAs who are prescribers of controlled medications should  
2619 register with the Federal Drug Enforcement Administration.

2620 Dispensing is also appropriate for PAs. The purpose of dispensing is not to  
2621 replace pharmacy services, but rather to increase patient ability to receive needed  
2622 medication when access to pharmacy services is limited. Pharmaceutical samples

2623 should be available to PAs just as they are to physicians for the management of  
2624 clinical problems.

2625 State laws, regulations, and policies should allow PAs to sign any forms that  
2626 require a physician signature.

2627 **Title and Practice Protection**

2628 The ability to utilize the title of “PA” or “asociado médico” when the  
2629 professional title is translated into Spanish should be limited to those who are  
2630 authorized to practice by their state as a PA. The title may also be utilized by those  
2631 who are exempted from state licensure but who are credentialed as a PA by a federal  
2632 employer and by those who meet all the qualifications for licensure in the state but  
2633 are not currently licensed. A person who is not authorized to practice as a PA should  
2634 not engage in PA practice unless similarly credentialed by a federal employer. The  
2635 state should have the clear authority to impose penalties on individuals who violate  
2636 these provisions.

2637 **Regulatory Agencies**

2638 Each state must define the regulatory agency responsible for  
2639 implementation of the law governing PAs. Although a variety of state agencies can  
2640 be charged with this task, the preferable regulatory structure is a separate PA  
2641 licensing board comprised of a majority of PAs, with other members who are  
2642 knowledgeable about PA education, certification, and practice. Consideration  
2643 should be given to including members who are representative of a broad spectrum  
2644 of healthcare settings — primary care, specialty care, institutional and rural based  
2645 practices.

2646 If regulation is administered by a multidisciplinary healing arts or medical  
2647 board, it is strongly recommended that PAs and physicians who practice with PAs be  
2648 full voting members of the board.

2649 Any state regulatory agency charged with PA licensure should be sensitive to the  
2650 manner in which it makes information available to the public. Consumers should be able  
2651 to obtain information on health professionals from the licensing agency, but the agency  
2652 must assure that information released does not create a risk of targeted harassment for  
2653 the PA licensee or their family.

2654 Although there is no conclusive evidence that malpractice claims history  
2655 correlates with professional competence, many state regulatory agencies are required  
2656 by statute to make malpractice history on licensees available to the public. If  
2657 mandated to do so, the board should create a balance between the public’s right to  
2658 relevant information about licensees and the risk of diminishing access to  
2659 subspecialty care. Because of the inherent risk of adverse outcomes, medical  
2660 professionals who care for patients with high- risk medical conditions are at greater  
2661 risk for malpractice claims. The board should take great care in assuring that patient  
2662 access to this specialized care is not hindered as a result of posting information that  
2663 could be misleading to the public.

2664 Licensee profiles should contain only information that is useful to  
2665 consumers in making decisions about their healthcare professional. Healthcare  
2666 professional profile data should be presented in a format that is easy to  
2667 understand and supported by contextual information to aid consumers in  
2668 evaluating its significance.

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**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.



2717

2718 AAPA also encourages state constituent organizations to advocate for the establishment  
2719 of supervised injection facilities.

2720

2721 **2018-B-18 – Referred (to be referred by the Speaker to the appropriate body and reported back**  
2722 **to the 2019 HOD)**

2723

2724 AAPA supports standards to require that PA training programs provide at least 80-  
2725 percent of didactic instruction as in-person or live lectures.

2726

2727 **2018-C-01 (Referred 2017-C-11) – Adopted as Amended**

2728

2729 Amend by substitution policy HP-3500.2.1 as follows:

2730

2731 AAPA ENDORSES THE NATIONAL COMMISSION ON CERTIFICATION OF  
2732 PHYSICIAN ASSISTANTS (NCCPA) CERTIFICATION EXAM AS THE ONLY  
2733 ENTRANCE STANDARD FOR PAS.

2734

2735 **2018-C-02 – Adopted on Consent Agenda**

2736

2737 Amend policy HP-3200.2.4 as follows:

2738

2739 AAPA **ADOPTS endorses the policies of** the Accreditation Council **FOR on** Continuing  
2740 Medical Education (ACCME) **STANDARDS FOR COMMERCIAL SUPPORT AND**  
2741 **ITS ASSOCIATED INTERPRETIVE POLICIES AS PART OF ITS OWN**  
2742 **ACCREDITATION SYSTEM. on commercial support of continuing medical education**  
2743 **(CME) and applies those standards to its own review process.**

2744

2745 **2018-C-03 – Adopted as Amended**

2746

2747 Amend by substitution policy HX-4600.1.8 entitled “Comprehensive Health Care  
2748 Reform”, with the policy paper entitled “Promoting the Delivery of Healthcare Services”.

2749

2750 **Promoting the Access, Coverage and Delivery of Healthcare Services**

2751

2752 **Executive Summary of Policy Contained in this Paper**

2753 **Summaries will lack rationale and background information and may lose nuance**  
2754 **of policy. You are highly encouraged to read the entire paper.**

2755

- 2756 • **AAPA believes the primary goal of our healthcare system is to ensure**  
2757 **that everyone in America has access to quality, affordable healthcare.**
- 2758 • **AAPA opposes policies that discriminate against patients on the basis**  
2759 **of pre-existing conditions, health status, race, gender SEX, age, socio-**  
2760 **economic status or other discriminatory demographic or geographic**  
2761 **factors.**
- 2762 • **AAPA supports a healthcare system that provides essential health**  
2763 **services to all patients.**



- 2764 • AAPA supports confronting resource and care limitations  
2765 while encouraging the use of evidence-based medicine and  
2766 comparative-effectiveness research.
- 2767 • AAPA supports policies that optimize the utilization of  
2768 primary care in our healthcare system.
- 2769 • AAPA supports policies that promote coordinated, patient-  
2770 focused care that improves quality and outcomes for patients  
2771 and their families.
- 2772 • AAPA supports placing emphasis on health and wellness promotion and  
2773 disease prevention.
- 2774 • AAPA supports patient choice of qualified providers, including PAs.
- 2775 • AAPA recognizes that reform may include changes to the medical  
2776 liability insurance system and are supportive of policies that enhance  
2777 transparency and trust between providers and patients.
- 2778 • AAPA is governed by these principles and is not an advocate for any  
2779 specific approach to restructuring or financing of the healthcare system.

2780  
2781 AAPA encourages policy makers to pursue policies that improve the  
2782 American healthcare system and ensure everyone in America has access to high-  
2783 quality, affordable healthcare. AAPA supports policies that prioritize meeting  
2784 patient needs through evidence-based medicine and that embrace AAPA's guiding  
2785 principles.

2786 AAPA's guiding principles promote policies that protect patients from  
2787 discrimination based on pre-existing conditions, health status, race, gender SEX,  
2788 socio-economic or other discriminatory demographic or health-related factors. The  
2789 principles also call for access to affordable high-quality healthcare coverage that  
2790 provides meaningful and robust coverage for all patients. As healthcare providers,  
2791 PAs believe all patients must have access to a range of essential health services  
2792 such as maternity care, emergency services, prescription drugs, and treatment for  
2793 substance abuse and mental health needs. Patients should be satisfied with the type  
2794 and quality of care being provided. Also, patients should be able to choose a  
2795 qualified provider that is the best fit for their needs without facing restrictions in  
2796 obtaining their medical care.

2797 In partnership with our patients and the broader healthcare community,  
2798 AAPA believes PAs and all healthcare providers should be held to the highest  
2799 professional standards of evidence-based care and medical ethics.

2800 AAPA and the PA profession are committed to working with the federal  
2801 government, states, territories, tribes, patients, and all stakeholders to improve the  
2802 United States' healthcare system. AAPA sets forth the following principles to  
2803 direct its efforts.

### 2804 **Principles**

- 2805 • AAPA believes the primary goal of our healthcare system is to ensure  
2806 that everyone in America has access to quality, affordable healthcare.
- 2807 • AAPA opposes policies that discriminate against patients on the basis  
2808 of pre-existing conditions, health status, race, gender SEX, age, socio-  
2809 economic status or other discriminatory demographic or geographic  
2810 factors.
- 2811 • AAPA supports a healthcare system that provides essential health

- 2812 services to all patients.
- 2813 • AAPA supports confronting resource and care limitations while
  - 2814 encouraging the use of evidence-based medicine and comparative-
  - 2815 effectiveness research.
  - 2816 • AAPA supports policies that optimize the utilization of primary care in
  - 2817 our healthcare system.
  - 2818 • AAPA supports policies that promote coordinated, patient-focused care
  - 2819 that improves quality and outcomes for patients and their families.
  - 2820 • AAPA supports placing emphasis on health and wellness promotion and
  - 2821 disease prevention.
  - 2822 • AAPA supports patient choice of qualified providers, including PAs.
  - 2823 • AAPA recognizes that reform may include changes to the medical
  - 2824 liability insurance system and are supportive of policies that enhance
  - 2825 transparency and trust between providers and patients.
  - 2826 • AAPA is governed by these principles and is not an advocate for any
  - 2827 specific approach to restructuring or financing of the healthcare system.

### 2828 **Conclusion**

2829 AAPA believes policies adopted at the state or federal level should protect  
2830 coverage for patients, assure access to care provided by PAs and other providers, as well  
2831 as maintain coverage of essential health benefits for our patients. Patients should have  
2832 access to a variety of health services and be satisfied with the type and quality of care  
2833 available. Patients should not experience restrictions due to pre-existing conditions or  
2834 face other arbitrary condition-based exclusions. We believe following these principles  
2835 will ensure access to high quality healthcare and improve the quality and transparency of  
2836 the care available to all Americans.

### 2837 2838 **Comprehensive Health Care Reform**

2839 (Adopted 2005, amended 2010, 2013)

2840  
2841 The American health care system requires coordinated and systematic reform in  
2842 order to meet the needs of the population, ensure quality, and control costs.

2843 AAPA is not an advocate for any specific structure of health care reform and  
2844 financing. The guiding principles must include access for all patients; evidence based  
2845 care; equitable distribution of care and resources; and a payment mechanism that is  
2846 portable and sustainable for individuals, families, and society.

2847 Patients should retain a choice of providers, have access to a variety of health  
2848 services, and should be satisfied with the type and quality of care offered by the providers  
2849 and the health care system without restrictions due to pre-existing and other arbitrary  
2850 condition-based exclusions. All providers, allopathic, osteopathic, and alternative, should  
2851 be held to the highest professional standards of evidence-based care and medical ethics.

2852 AAPA and the PA profession are committed to working with federal and state  
2853 legislatures and all involved parties to plan and implement a fair and comprehensive  
2854 reform of the United States health care system.

2855 AAPA sets forth the following principles to direct its efforts on health care  
2856 reform.

2857 AAPA believes the primary goal of comprehensive health care system reform is  
2858 to ensure access to quality, affordable, and cost-efficient health care for all patients.

2859 AAPA supports a health care system that will provide basic services to all  
2860 patients.  
2861 AAPA supports health care that is delivered by qualified providers in physician-  
2862 directed teams.  
2863 AAPA supports reform that confronts the limits of care and resources and  
2864 encourages the use of evidence-based medicine and the utilization of comparative-  
2865 effectiveness information.  
2866 AAPA supports the optimal utilization of primary care in a reformed health  
2867 system.  
2868 AAPA supports an emphasis on health promotion and disease prevention in health  
2869 care reform.  
2870 AAPA believes that fair and comprehensive reform of the medical liability  
2871 insurance system is needed and encourages health care professionals to apologize for  
2872 adverse outcomes without increasing risk.  
2873 AAPA endorses system reform that enhances the relationship between the patient  
2874 and the clinician.  
2875 Additionally, AAPA believes that a long range solution to the Medicare physician  
2876 payment system must be part of health care reform.  
2877

#### 2878 **2018-C-04 – Adopted as Amended**

2879  
2880 Amend policy HP-3200.5.3 as follows:

2881  
2882 AAPA believes it is sound public policy to strengthen the U.S. health care workforce by  
2883 providing federal and state government support for PA education. Such support includes  
2884 expanded student loans and scholarships including National Health Service Corps  
2885 scholarships and loan repayment programs; **QUALIFIED CLINICAL**  
2886 **POSTGRADUATE PROGRAMS**; and federal grants and faculty development initiatives;  
2887 and other forms of assistance including research. Grants to PA programs should include  
2888 investments to expand high quality clinical education sites where PA students can train  
2889 and function with interprofessional teams. Government funding for PA education to  
2890 maintain and expand PA education and faculty training, **ALONG WITH OPTIONAL**  
2891 **QUALIFIED CLINICAL-POSTGRADUATE PROGRAMS**, will help assure the highest  
2892 level of health care delivery in the United States. Government funding for research on  
2893 best practices in education will ensure that effective educational outcomes will lead to  
2894 high quality, safe health care delivery.  
2895

2896 **WHILE AAPA MAINTAINS ITS BELIEF THAT ADEQUATE KNOWLEDGE IS**  
2897 **OBTAINED THROUGH PA EDUCATION FOR PROFESSIONAL PRACTICE, PAS**  
2898 **HAVE THE OPPORTUNITY TO INCREASE THEIR KNOWLEDGE THROUGH**  
2899 **OPTIONAL CLINICAL-POSTGRADUATE TRAINING PROGRAMS. ELIGIBLE PA**  
2900 **POSTGRADUATE TRAINING PROGRAMS SHOULD QUALIFY FOR ANY**  
2901 **FEDERAL OR STATE FUNDING AVAILABLE TO OTHER ELIGIBLE NON-**  
2902 **PHYSICIAN POSTGRADUATE TRAINING PROGRAMS.**  
2903

#### 2904 **2018-C-05 – Adopted on Consent Agenda**

2905  
2906 Amend by substitution policy HP-3300.1.11.1 as follows:

2907  
2908 AAPA encourages PAs to become educated about the prevention and management of  
2909 being overweight and obese for both adult and pediatric populations, and to take an active  
2910 leadership role in educating their patients and the public about the health risks of being  
2911 overweight and obese. PAs are encouraged to address the issues of healthy weight and  
2912 regular physical activity as critical components of health promotion/health maintenance  
2913 for adults and children in their care. Additionally, PAs are encouraged to be proficient in  
2914 identifying and treating obesity-related disease states and comorbidities. PAs themselves  
2915 are encouraged to maintain a healthy weight in order to set the best example for their  
2916 patients.

2917  
2918 AAPA encourages the PA profession to combat the epidemic of childhood obesity within  
2919 their clinical practices and to collaborate with public health organizations and federal  
2920 agencies to meet the goals of improved nutritional education in schools, expanded  
2921 physical education and exercise programs, and healthier eating habits in the home.  
2922 *[Adopted 2014]*

2923  
2924 AAPA ENCOURAGES PAS TO BECOME EDUCATED ABOUT THE PREVENTION  
2925 AND TREATMENT OF OVERWEIGHT AND OBESITY FOR BOTH THE ADULT  
2926 AND PEDIATRIC POPULATION. AAPA ENCOURAGES PAS TO TAKE AN  
2927 ACTIVE LEADERSHIP ROLE IN EDUCATING THEIR PATIENTS AND THE  
2928 PUBLIC ABOUT THE CHRONIC AND MULTI-FACTORIAL NATURE OF THE  
2929 DISEASE OF OBESITY, WHICH INCLUDES GENETIC FACTORS, INFECTIONS,  
2930 HYPOTHALAMIC INJURY, WEIGHT PROMOTING MEDICATIONS, WEIGHT  
2931 PROMOTING MEDICAL CONDITIONS, NUTRITIONAL IMBALANCE, AND/OR  
2932 ENVIRONMENTAL FACTORS.

2933  
2934 PAS ARE ENCOURAGED TO UNDERSTAND ADIPOSOPATHY AND HOW THIS  
2935 CONTRIBUTES TO METABOLIC DISEASE PAS ARE ENCOURAGED TO  
2936 UNDERSTAND HOW PHYSICAL FORCES FROM EXCESS BODY FAT  
2937 CONTRIBUTE TO BIOMECHANICAL HEALTH CONSEQUENCES OF OBESITY.  
2938 AAPA ALSO ENCOURAGES PAS TO BECOME EDUCATED ON OBESITY  
2939 STIGMA AND WEIGHT BIAS, AND HOW THIS CAN IMPACT PATIENT CARE  
2940 AND A PATIENT'S HEALTH. AAPA ENCOURAGES PAS TO USE PERSON-FIRST  
2941 LANGUAGE AND NON-STIGMATIZING OBESITY TERMINOLOGY, AS WELL  
2942 AS TO PROVIDE AN OFFICE ENVIRONMENT WHICH COMFORTABLY  
2943 ACCOMMODATES PATIENTS WITH OBESITY.

2944  
2945 AAPA ENCOURAGES PAS TO BE EDUCATED ON THE APPROPRIATE  
2946 DIAGNOSIS AND ASSESSMENT OF A PATIENT WITH OVERWEIGHT OR  
2947 OBESITY, AS WELL AS ON HOW TO FORMULATE A COMPREHENSIVE  
2948 TREATMENT PLAN, INCLUDING NUTRITION, PHYSICAL ACTIVITY,  
2949 BEHAVIOR MODIFICATION, AND, IF MEDICALLY APPROPRIATE,  
2950 PHARMACOLOGY, AND BARIATRIC SURGERY/ ENDOSCOPIC PROCEDURES.  
2951 PAS ARE ENCOURAGED TO HAVE REFERRAL SOURCES AVAILABLE FOR  
2952 PATIENTS WITH OVERWEIGHT AND OBESITY WHEN APPROPRIATE, AND  
2953 REFER TO OBESITY MEDICINE SPECIALISTS AND/ OR BARIATRIC

2954 PROGRAMS, EXERCISE PHYSIOLOGISTS, DIETITIANS, SLEEP SPECIALISTS,  
2955 PSYCHOLOGISTS, OR OTHER REFERRAL SOURCES, WHEN NEEDED.

2956  
2957 **2018-C-06 – Adopted**

2958  
2959 Amend by substitution policies HP-3300.1.8.1 and HP-3300.1.8.2 as follows:

2960  
2961 **HP 3300.1.8.1**  
2962 PAs knowledgeable in the area of organ and tissue transplantation should become  
2963 actively involved with educating the public and other health professionals.  
2964 [~~Adopted 1985, reaffirmed 1990, 1995, 2000, 2010, amended 2005, 2015~~]

2965  
2966 **HP 3300.1.8.2**  
2967 AAPA encourages PAs to be familiar with criteria for identifying potential organ/tissue  
2968 donors and to be involved where appropriate in the “request” for donation and subsequent  
2969 acquisition of organ/tissue donation as is medically indicated.  
2970 [~~Adopted 1988, reaffirmed 1993, 1998, 2003, 2008, 2013~~]

2971  
2972 AAPA ENCOURAGES PAS TO BE FAMILIAR WITH THE CRITERIA FOR  
2973 IDENTIFYING POTENTIAL ORGAN/TISSUE DONORS AND SUPPORTS MULTI-  
2974 ORGAN AND TISSUE DONATION. PAS SHOULD BE INVOLVED WHERE  
2975 APPROPRIATE IN THE DISCUSSION REGARDING DONATION AND  
2976 SUBSEQUENT ACQUISITION OF ORGAN/TISSUE DONATION AS IS  
2977 MEDICALLY INDICATED. FURTHERMORE, PAS WHO ARE KNOWLEDGEABLE  
2978 IN THE AREA OF ORGAN AND TISSUE DONATION AND TRANSPLANTATION  
2979 SHOULD BE ACTIVELY INVOLVED IN EDUCATION OF THOSE IN  
2980 HEALTHCARE AS WELL AS THE GENERAL PUBLIC.

2981  
2982 **2018-C-07 – Adopted on Consent Agenda**

2983  
2984 Amend by substitution policies HX-4200.5.1 and HX-4200.5.2 as follows:

2985  
2986 **HX 4200.5.1** AAPA supports multi-organ and tissue donation.  
2987 [~~Adopted 1985, amended 2005, reaffirmed 1990, 1995, 2000, 2010, 2015~~]

2988  
2989 **HX 4200.5.2** AAPA support the concept that organs and tissue for transplantation should  
2990 be made available based on need, rather than ability to pay.  
2991 [~~Adopted 1986, amended 2006, reaffirmed 1991, 1996, 2001, 2011, 2016~~]

2992  
2993 AAPA SUPPORTS ORGAN AND TISSUE DONATION AND NOTES THAT  
2994 TRANSPLANTATION SHOULD BE MADE AVAILABLE BASED ON NEED  
2995 RATHER THAN ABILITY TO PAY.

2996  
2997 **2018-C-08 – Adopted as Amended**

2998  
2999 Amend policy HX-4100.1.10 as follows:

3000

3001 ~~AAPA respects the racial, ethnic, and cultural, diversity of all people. The Academy's~~  
3002 ~~AAPA IS COMMITTED TO RESPECTING THE VALUES AND DIVERSITY OF~~  
3003 ~~ALL INDIVIDUALS IRRESPECTIVE OF RACE, ETHNICITY, CULTURE, FAITH,~~  
3004 ~~GENDER SEX, GENDER IDENTITY OR EXPRESSION AND SEXUAL~~  
3005 ~~ORIENTATION. commitment to diversity values all individuals.~~ When differences  
3006 between people are respected everyone benefits. Embracing diversity celebrates the rich  
3007 heritage of all communities and promotes understanding and respect for the differences  
3008 among all people.

3009  
3010 **2018-C-09 – Adopted as Amended**

3011  
3012 AAPA believes consumer-ordered testing, including, but not limited to, genetic testing,  
3013 should **HAVE RESULTS AND POTENTIAL CLINICAL IMPLICATIONS**  
3014 **INTERPRETED** ~~be DONE~~ ~~conducted under the guidance of and~~ in collaboration with a  
3015 qualified healthcare provider and/or genetic counselor.

3016  
3017 **2018-C-10 – Adopted on Consent Agenda**

3018  
3019 Amend policy HX-4100.1.8 as follows:

3020  
3021 AAPA endorses the ~~1975~~ World Medical Association Declaration of Tokyo which  
3022 provides guidelines ~~for physicians and, by nature of their dependent relationship, for PAs,~~  
3023 ~~in cases of~~ **CONCERNING** torture or other cruel, inhuman or degrading treatment or  
3024 punishment in relation to detention and imprisonment.

3025  
3026 **2018-C-11 – Adopted on Consent Agenda**

3027  
3028 AAPA supports the use of Patient Drug Monitoring Programs (PDMP) for the prescribing  
3029 and dispensing of controlled substances at the state level.

3030  
3031 AAPA supports the ability of prescribers and dispensers to query other states for similar  
3032 information.

3033  
3034 **2018-C-12 – Adopted on Consent Agenda**

3035  
3036 AAPA believes that palliative medicine is a core component of PA practice and  
3037 encourages all PAs to acquire training in this discipline commensurate with their clinical  
3038 practice.

3039  
3040 And, be it further resolved,

3041  
3042 AAPA supports inclusion of PAs in any proposed educational funding for health care  
3043 providers in hospice and palliative medicine.

3044  
3045 And, be it further resolved that,

3046



3047 AAPA believes in partnering with other relevant associations including the PAEA,  
3048 Patient Quality of Life Coalition (PQLC), American Academy of Hospice and Palliative  
3049 Medicine (AAHPM), and ARC-PA to advance the progress of palliative care education.

3050

3051 **2018-C-13 – Adopted as Amended**

3052

3053 AAPA supports initiatives for increased funding for development and operation **OF PA**  
3054 **PROGRAMS AT** ~~for~~ Historically Black Colleges and Universities, **(HBCU), and**  
3055 **PREDOMINANTLY BLACK INSTITUTIONS,** Hispanic-Serving Institutions **(HSI),**  
3056 **AND RURAL SERVING INSTITUTIONS.**

3057

3058 **2018-C-14 – Adopted**

3059

3060 AAPA supports initiatives for increased federal loan limits to provide parity with loan  
3061 limits available to other health care professional students.

3062

3063 **2018-C-15 – Adopted on Consent Agenda**

3064

3065 AAPA supports the removal of federal restrictions on the study of gun violence by the  
3066 CDC.

3067

3068 **2018-C-16 – Referred (to be referred by the Speaker to the appropriate body and reported back**  
3069 **to the 2019 HOD)**

3070

3071 Adopt the policy paper entitled “Restriction of the Use of Opioid Containing Medications  
3072 in Children”.

3073

3074 **Restriction of the Use of Opioid Containing Medications in Children**

3075

3076 **Executive Summary of Policy Contained in this Paper**

3077

3078 Summaries will lack rationale and background information, and may lose nuance of  
3079 policy. You are highly encouraged to read the entire paper.

3080

- 3081 • AAPA supports regulations and legislation that restrict the use of opioid  
3082 containing medications in children.
- 3083 • AAPA supports the Food and Drug Administration’s efforts to curtail the  
3084 prescribing of opioid containing medications to children by healthcare providers.
- 3085 • PAs should be aware of the dangers of the use of codeine and hydrocodone in  
3086 children, and should limit their use as treatments for cough suppression, and of  
3087 codeine for pain.

3088

3089 In 2016 the FDA examined the use of opioid medications in response to the  
3090 opioid abuse epidemic. Codeine products and hydrocodone including opioid-containing  
3091 antitussive (OCA) products and pain medications came under scrutiny with their use in  
3092 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.<sup>1</sup> Potential

3093 adverse side effects from codeine are respiratory depression and death, particularly in  
3094 children under the age of 12 years.<sup>2</sup>

3095 It has been well established that there is limited evidence that cough suppression  
3096 in children is necessary or beneficial, and that the medications available have little  
3097 efficacy.<sup>1,3,4</sup> It has also been reported that the use of codeine for pain post-operatively for  
3098 adenotonsillectomy for obstructive sleep apnea (OSA) carried a higher risk for death.<sup>2</sup>  
3099 Therefore in April 2017 the FDA issued a contraindication to using codeine to treat pain  
3100 or cough in children under the age of 12 years, and a warning about using it in children  
3101 aged 12 – 18 years who are obese or who have OSA or severe lung disease. In January,  
3102 2018 the FDA went a step further in stripping both codeine and hydrocodone of the  
3103 indication for the treatment of cough in children younger than the age of 18 years, and  
3104 codeine for treatment of pain.

3105 With the United States currently battling an opioid abuse epidemic, PAs need to  
3106 be aware of these new recommendations and put them into practice. PAs further need to  
3107 provide information to families about the FDA's stance on the use of OCA products, and  
3108 of codeine for pain. PAs would benefit from educational opportunities covering more  
3109 effective treatment modalities for cough and pain management.

### 3110 **Conclusion**

3111 AAPA supports regulations and legislation that restricts the use of codeine and  
3112 hydrocodone in children under the age of 18 years. AAPA stands in support of the  
3113 FDA's new recommendations for the restriction of the use of opioid containing  
3114 medications for the treatment of cough and pain in children. AAPA encourages all PAs  
3115 to be aware of the dangers of these medications in children. AAPA further encourages all  
3116 PAs to keep prescribing practices in line with evidence based medicine and the  
3117 recommendations of the FDA.

### 3118 **References**

- 3119 1. Gardiner, S, Chang, A, Marchant, J, Petsky, H. Codeine versus placebo for  
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- 3122 2. Tobias, JD, Green TP, Cote, CJ. Codeine : Time to Say “No”. *Pediatrics*.  
3123 2016;138(4):e1-e6.
- 3124 3. Carr, BC. Efficacy, abuse, and toxicity of over-the-counter cough and cold  
3125 medicines in the pediatric population. *Current Opinion in Pediatrics*.  
3126 2006;18:184-188.
- 3127 4. Food and Drug Administration News Release. FDA acts to protect kids from  
3128 serious risks of opioid ingredients contained in some prescription cough and cold  
3129 products by revising labeling to limit pediatric use.  
3130 [https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm592109.h](https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm592109.htm)  
3131 [tm](https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm592109.htm). January 11, 2018.

### 3132 3133 **2018-C-17 – Adopted on Consent Agenda**

3134  
3135 Amend policy HX-4400.1.1 as follows:

3136  
3137 AAPA believes that PAs should be familiar with social and cognitive skills that foster  
3138 non-violent conflict resolution. In addition, PAs should support the incorporation of age-  
3139 appropriate school and community-based curricula that recognize racial, ethnic,

3140 **SEXUAL AND GENDER MINORITY**, ~~and~~ cultural, **AND RELIGIOUS** diversity and  
3141 that teach the skills of non-violent conflict resolution.

3142

3143 **2018-C-18 – Adopted**

3144

3145 APA supports the National Action Alliance for Suicide Prevention’s report,  
3146 “Recommended Standard Care for People with Suicide Risk: Making Health Care  
3147 Suicide Safe”, as a guide for PAs.

3148

3149 And further resolved

3150

3151 The HOD recommends that AAPA develops a communication strategy to inform its  
3152 members.

3153

3154 And further resolved

3155

3156 The HOD recommends that AAPA communicate this information to PAEA to consider  
3157 for inclusion in PA program curriculums.

3158

3159 And further resolved

3160

3161 The HOD recommends that AAPA includes this information in future AAPA CME  
3162 activities.

3163

3164 **Resolution of Condolence**

3165

3166 **2018-COND-01**

3167

**Resolution of Condolence**

3168

**John Sallstrom, PA-C**

3169

**May 2018**

3170

3171  
3172 Whereas, the North Carolina Academy of PAs suffered a great loss with the untimely passing of  
3173 John Sallstrom on April 6, 2018, and

3174

3175 Whereas John graduated from the PA Program at the Nebraska College of Medicine in 1975, and

3176

3177 Whereas John served as a PA in the Air Force and retired as a Major, and

3178

3179 Whereas John moved to Morganton, NC in 1988 and worked as a PA at Burke Primary Care  
3180 providing for medical services for the citizens of Burke County, and

3181

3182 Whereas John served on the Stead Center Task Force which brought the vision to have the North  
3183 Carolina Academy of PAs have a permanent house in North Carolina, and

3184

3185 Whereas John served as President-elect, President and Past President of the North Carolina  
3186 Academy of PAs from 2009-2011, and

3187

3188 Whereas John served as Chief Delegate from North Carolina in the AAPA House of Delegates in  
3189 2010,

3190  
3191 Whereas John served as the President of North Carolina Academy of PAs Endowment from 2004  
3192 until 2008, and

3193  
3194 Whereas John worked diligently on behalf of the North Carolina Academy of PAs Endowment to  
3195 further the success of the philanthropic arm of the state's PA professional organization, and

3196  
3197 And whereas John's kind, gentle soft-spoken manner served to help move the PA profession  
3198 forward in North Carolina, be it

3199  
3200 Resolved that the House of Delegates of the AAPA recognize John Sallstrom for his many  
3201 contributions to the PA profession and the care he provided to his many patients, and be it further

3202  
3203 Resolved, a copy of this resolution be provided to his family with deepest sympathy from the  
3204 members of the AAPA.

3205

3206 **House Elections 2018**

**Results**

3207

3208 **Vice President/Speaker**

David Jackson

3209 **First Vice Speaker**

William Reynolds

3210 **Second Vice Speaker**

Todd Pickard

3211

3212 **Nominating Work Group**

Peggy Walsh

3213

Monica Ward