2012 Summary of Actions
AAPA House of Delegates
Toronto, Ontario
May 26-28, 2012

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Bolded text within a resolution indicates the amendments submitted and accepted during the reports of the reference committees on May 28, 2012.

Presiding Officers

Alan Hull, PA-C	Speaker
L. Gail Curtis, MPAS, PA-C, DFAAPA	First Vice Speaker
David Jackson, MPAS, RPA-C, DFAAPA	Second Vice Speaker

2012-A-01 – Adopted on Consent Agenda

Amend AAPA Bylaws as follows:

ARTICLE VI House of Delegates.

Section 1: Duties and Responsibilities. The Academy shall have a House of Delegates, which shall represent the interests of the membership. The House of Delegates shall exercise the sole authority on behalf of the Academy to enact policies establishing the collective values, philosophies, and principles of the physician assistant profession. The House of Delegates shall make recommendations to the Board for granting charters to Chapters and for granting official recognition to ~~caucuses and~~ specialty physician assistant organizations. The House of Delegates shall make recommendations to the Board for the establishment of Academy commissions and work groups, and shall establish such committees of the House of Delegates as necessary to fulfill its duties. The House of Delegates shall be entitled to vote on amendments to these Bylaws on behalf of the members in accordance with Article XIII of these Bylaws. The House of Delegates shall be solely responsible for establishing such rules of procedure, which are not inconsistent with these Bylaws, the Articles of Incorporation, or existing law, as may be necessary for carrying out the activities of the House (i.e. House of Delegates Standing Rules).

Section 2: Composition. The voting membership of the House of Delegates shall consist of the immediate past and current House Officers, one delegate elected by each officially recognized specialty physician assistant organization, one delegate ~~elected by the Caucus Congress~~ FROM EACH CAUCUS, delegates elected by fellow members of Chapters, and delegates elected by the Student Academy of the American Academy of Physician Assistants. All delegates, other than those of the Student Academy of the American Academy of Physician Assistants, shall be fellow members of the Academy. The delegates from the Chapters, specialty physician assistant organizations, and ~~the Caucus Congress~~ CAUCUSES are elected by the fellow members of those organizations. Chapter and Student Academy delegate seats shall be allocated as follows:

ARTICLE VII Board of Directors and Officers of the Corporation.

Section 1: Board Duties and Responsibilities. The Academy shall have a Board of Directors, which, in accordance with North Carolina law, shall be responsible for the management of the Corporation, including, but not limited to, management of the Corporation's property, business, and financial affairs. In addition to the duties and responsibilities conferred upon it by statute, by the Articles of Incorporation, or by these Bylaws, it is expressly declared that the Board of Directors shall have the following duties and responsibilities:

a. To grant such charters to Chapters, recognize such ~~caucuses and~~ specialty physician assistant organizations, ESTABLISH CRITERIA FOR CAUCUSES, and establish such Academy commissions or work groups as may be in the best interests of the Academy, taking into consideration any recommendations of the House of Delegates thereon;

ARTICLE XIV Amendments.

Section 2: A proposal for the amendment or repeal of existing Bylaws provisions or adoption of new Bylaws provisions shall be initiated by (a) the Board of Directors, (b) any commission ~~or the Caucus Congress~~, (c) any Chapter, (d) any officially recognized specialty physician assistant organization, (e) ANY CAUCUS, (F) the Student Academy, or (~~f~~G) the collective House Officers.

2012-A-02 – Adopted

Amend AAPA Bylaws as follows:

ARTICLE IV Constituent ~~Chapters~~ ORGANIZATIONS.
~~A constituent chapter shall be defined as an organization consisting of AAPA fellow members and that has a current charter from the Academy (henceforth referred to as "Chapters").~~
CONSTITUENT ORGANIZATIONS CONSIST OF STATE AND FEDERAL SERVICES CHAPTERS, SPECIALTY ORGANIZATIONS, CAUCUSES AND SPECIAL INTEREST GROUPS, AS DEFINED IN AAPA POLICY.

ARTICLE VI House of Delegates.

Section 1: Duties and Responsibilities. The Academy shall have a House of Delegates, which shall represent the interests of the membership. The House of Delegates shall exercise the sole authority on behalf of the Academy to enact policies establishing the collective values, philosophies, and principles of the physician assistant profession. The House of Delegates shall make recommendations to the Board for granting charters to Chapters and for granting official recognition to caucuses and specialty ~~physician assistant~~ organizations. The House of Delegates shall make recommendations to the Board for the establishment of Academy commissions and work groups, and shall establish such committees of the House of Delegates as necessary to fulfill its duties. The House of Delegates shall be entitled to vote on amendments to these Bylaws on behalf of the members in accordance with Article XIII of these Bylaws. The House of Delegates shall be solely responsible for establishing such rules of procedure, which are not inconsistent with these Bylaws, the Articles of Incorporation, or existing law, as may be necessary for carrying out the activities of the House (i.e. House of Delegates Standing Rules).

Section 2: Composition. The voting membership of the House of Delegates shall consist of the immediate past and current House Officers, one delegate elected by each officially recognized specialty ~~physician assistant~~ organization, one delegate elected by the Caucus Congress, delegates ~~elected by fellow members of~~ FROM Chapters, and delegates ~~elected by~~ FROM the Student Academy of the American Academy of Physician Assistants. All delegates, other than those of the Student Academy ~~of the American Academy of Physician Assistants,~~ shall be fellow members of the Academy. STUDENT DELEGATES SHALL BE STUDENT OR FELLOW MEMBERS OF THE

ACADEMY. The delegates from the Chapters, specialty ~~physician assistant~~ organizations, and the Caucus Congress are elected by the fellow members of those organizations. Chapter and Student Academy delegate seats shall be allocated as follows:

a. Chapter Delegates. Each Chapter shall be entitled to two (2) delegates. Additional delegates will be apportioned among the Chapters according to the number of Academy fellow members within the jurisdiction of each ~~Chapter~~ as of January 31 of each year. When the number of fellow members within a Chapter's jurisdiction exceeds 220, ~~the Chapter~~ IT will be apportioned a third delegate. An additional delegate will be apportioned for each 300 additional members within a Chapter's jurisdiction thereafter. The Academy's Constituent Relations Work Group will develop and recommend to the Board the definition of the Chapters' jurisdiction.

ARTICLE VII Board of Directors and Officers of the Corporation.

Section 1: Board Duties and Responsibilities. The Academy shall have a Board of Directors, which, in accordance with North Carolina law, shall be responsible for the management of the Corporation, including, but not limited to, management of the Corporation's property, business, and financial affairs. In addition to the duties and responsibilities conferred upon it by statute, by the Articles of Incorporation, or by these Bylaws, it is expressly declared that the Board of Directors shall have the following duties and responsibilities:

a. To grant ~~such~~ charters to Chapters, recognize ~~such~~ caucuses and specialty ~~physician assistant~~ organizations, and establish ~~such~~ Academy commissions or work groups as may be in the best interests of the Academy, taking into consideration any recommendations of the House of Delegates thereon;

ARTICLE XIV Amendments.

Section 2: A proposal for the amendment or repeal of existing Bylaws provisions or adoption of new Bylaws provisions shall be initiated by (a) the Board of Directors, (b) any commission or the Caucus Congress, (c) any Chapter, (d) any officially recognized specialty ~~physician assistant~~ organization, (e) the Student Academy, or (f) the collective House Officers.

2012-A-03 – Adopted

Amend AAPA Bylaws Articles VI and XIV as follows:

ARTICLE VI House of Delegates.

Section 4: Meetings of the House of Delegates.

a. Annual and Special Meetings. The House of Delegates shall hold an annual meeting. Special meetings of the House of Delegates shall be called by the Speaker upon written request of 25 percent or more of the delegates. Special meetings of the House shall also be called by a two-thirds (2/3) affirmative vote of the Board of Directors. The object of such special meetings shall be stated in the meeting notice, and no other business other than that specified in the notice shall be transacted at the meeting

b. Notice. Notice of the place, date, and time of meetings of the House of Delegates shall be given to each member of the House of Delegates at least 30 days but not more than 60 days before the meeting date. If proposed Bylaws amendments are to be presented to the House of Delegates for approval at the annual House meeting, the notice of the meeting shall include a description of the proposed amendments to be approved, and must be accompanied by a copy or summary of the proposed amendments. Notice of a special meeting shall include a description of the matter or matters for which the meeting is called. Notice may be delivered by electronic means.

c. Quorum. A majority of the total number of delegates shall constitute a quorum at any meeting of the House of Delegates. Unless otherwise stated in the Bylaws, an affirmative vote by a majority of the delegates present and voting shall constitute action of the House.

d. Mail and Electronic Voting. Mail and electronic voting of the House of Delegates will be permitted for any House business. ~~other than business requiring Bylaws changes.~~ Mail and electronic votes will be called for by the Speaker of the House when directed by: (i) a simple majority of the House Officers; (ii) a two-thirds affirmative vote of the Board of Directors; or (iii) a call from 25 percent of delegates currently credentialed. Additionally, mail and electronic votes will be called for by the Speaker when there is a vacancy in an elected office of the House during the time period between regularly scheduled House elections. The House of Delegates Officers and Academy staff shall determine the procedures for voting on issues requiring a mail or electronic ballot, subject to the requirements of the North Carolina Nonprofit Corporation Act.

ARTICLE XIV Amendments.

Section 1: To be adopted, an amendment to these Bylaws shall be approved by the Board of Directors and by a two-thirds (2/3) vote of all delegates present and voting of the House of Delegates.

Section 2: A proposal for the amendment or repeal of existing Bylaws provisions or adoption of new Bylaws provisions shall be initiated by (a) the Board of Directors, (b) any commission or the Caucus Congress, (c) any Chapter, (d) any officially recognized specialty physician assistant organization, (e) the Student Academy, or (f) the collective House Officers.

Section 3: Proposed amendments shall be in such form as the Academy's Judicial Affairs Work Group prescribes. ~~Each amendment shall be filed with the Work Group at least three (3) months prior to the annual meeting of the House of Delegates. The Judicial Affairs Work Group shall be exempt from the three (3) month filing requirement.~~

SECTION 4: AMENDMENTS MAY BE FILED FOR PRESENTATION AT THE NEXT ANNUAL MEETING OF THE HOUSE OF DELEGATES OR FOR CONSIDERATION IN AN ELECTRONIC VOTE.

SECTION 5: EACH AMENDMENT TO BE PRESENTED AT THE ANNUAL MEETING OF THE HOUSE OF DELEGATES SHALL BE FILED WITH THE WORK GROUP AT LEAST THREE (3) MONTHS PRIOR TO THAT MEETING. THE JUDICIAL AFFAIRS WORK GROUP'S PROPOSED AMENDMENTS SHALL BE EXEMPT FROM THE THREE (3) MONTH FILING REQUIREMENT.

a. TO BE CONSIDERED FOR ELECTRONIC VOTE OF THE HOUSE OF DELEGATES, AMENDMENTS MUST BE SUBMITTED 150 DAYS OR GREATER BEFORE THE ANNUAL MEETING OF THE HOUSE OF DELEGATES.

SECTION 6: PROPOSALS THAT ARE NOT INITIATED BY THE BOARD OF DIRECTORS WILL BE PRESENTED TO THE BOARD OF DIRECTORS SUBSTANTIALLY IN THE FORM PRESENTED TO THE WORK GROUP WITH SUCH TECHNICAL CHANGES AND CONFORMING AMENDMENTS TO THE PROPOSAL OR EXISTING BYLAWS AS THE WORK GROUP SHALL DEEM NECESSARY OR DESIRABLE.

a. IF FOR PRESENTATION AT THE NEXT ANNUAL HOUSE OF DELEGATES MEETING, THE PROPOSAL MUST BE CONSIDERED AND ACTED UPON AT LEAST 60 DAYS PRIOR TO THE ANNUAL MEETING OF THE HOUSE. THE PROPOSED AMENDMENTS ALONG WITH THE BOARD OF DIRECTORS' ACTION THEREON, SHALL BE DISTRIBUTED, IN THE FORM APPROVED BY THE BOARD OF DIRECTORS, TO EACH MEMBER OF THE HOUSE OF DELEGATES AT LEAST 30 DAYS PRIOR TO THE ANNUAL HOUSE MEETING IN CONNECTION WITH THE MEETING NOTICE REQUIRED BY ARTICLE VI, SECTION 4.

b. IF THE PROPOSAL IS TO BE SUBMITTED FOR ELECTRONIC CONSIDERATION OF THE HOUSE OF DELEGATES, THE PROPOSED AMENDMENTS ALONG WITH THE BOARD OF DIRECTORS' ACTION THEREON, SHALL BE DISTRIBUTED, IN THE FORM APPROVED BY THE BOARD OF DIRECTORS, TO EACH MEMBER OF THE HOUSE OF DELEGATES WITHIN 15 DAYS OF BOARD OF DIRECTORS' ACTION. THE HOUSE OF DELEGATES WILL THEN VOTE ON THE PROPOSAL IN ACCORDANCE WITH THE STANDING RULES ON ELECTRONIC VOTING.

SECTION 7: PROPOSED AMENDMENTS THAT COME TO THE HOUSE OF DELEGATES WITH THE PRIOR APPROVAL OF THE BOARD OF DIRECTORS WILL BECOME EFFECTIVE UPON APPROVAL OF THE HOUSE BY A TWO-THIRDS (2/3) VOTE OF ALL DELEGATES PRESENT AND VOTING.

SECTION 8: IF THE HOUSE OF DELEGATES APPROVES A PROPOSED AMENDMENT BY A TWO-THIRDS (2/3) VOTE OF ALL DELEGATES PRESENT AND VOTING, THAT WAS EITHER NOT APPROVED BY THE BOARD OF DIRECTORS, OR WAS AMENDED BY THE HOUSE OF DELEGATES, THEN THE PROPOSED AMENDMENT AS PASSED BY THE HOUSE OF DELEGATES, WILL BE SUBMITTED TO THE BOARD OF DIRECTORS FOR ITS ACTION.

~~Section 4: Except for proposals initiated by the Board of Directors, the Judicial Affairs Work Group shall present each proposal to the Board of Directors substantially in the form presented to the Work Group with such technical changes and conforming amendments to the proposal or existing Bylaws as the Work Group shall deem necessary or desirable. The proposed amendment(s) shall be presented to the Board of Directors for consideration and approval at least 60 days prior to the annual House meeting. All such amendments approved by the Board of Directors shall be distributed, in the form approved by the Board of Directors, to each member of the House of Delegates at least 30 days prior to the annual House meeting in connection with the meeting notice required by Article VI, Section 4.~~

~~Section 5: In the event that amendments presented to the Board of Directors pursuant to Section 4 of this Article are not approved by the Board, the Judicial Affairs Work Group shall distribute such amendments, in the form presented to the Board of Directors, to each member of the House of Delegates at least 30 days prior to the annual House meeting in connection with the meeting notice required by Article VI, Section 4. If the House of Delegates approves any such amendments at the annual House meeting by a two-thirds (2/3) vote of all delegates present and voting, the amendments as approved by the House shall be resubmitted to the Board of Directors for the Board's reconsideration.~~

2012-A-04 – Rejected

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

ARTICLE III <u>Membership.</u>

Section 3: <u>Fellow Members.</u> A fellow member shall be a physician assistant who is a graduate of a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation [CAHEA], Commission on Accreditation of Allied Health Education Programs [CAAHEP]) or who has passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) or an examination administered by another agency approved by the Academy. Fellow members must satisfy such continuing medical and/or medically related educational requirements as may be prescribed by the Academy. Non-clinical fellow members will not be required to maintain continuing medical education (CME). Fellow members shall vote for PRESIDENT-ELECT AND SECRETARY-TREASURER ~~Academy Officers and Directors, with the exception of the Vice President and Student Director~~, IN ACCORDANCE WITH ARTICLE VI, SECTION 3, and shall be eligible to hold office.

ARTICLE VI House of Delegates.

Section 1: Duties and Responsibilities. The Academy shall have a House of Delegates, which shall represent the interests of the membership. The House of Delegates shall exercise the sole authority on behalf of the Academy to enact policies establishing the collective values, philosophies, and principles of the physician assistant profession. The House of Delegates shall make recommendations to the Board for granting charters to Chapters and for granting official recognition to caucuses and specialty physician assistant organizations. The House of Delegates shall make recommendations to the Board for the establishment of Academy commissions and work groups, and shall establish such committees of the House of Delegates as necessary to fulfill its duties. The House of Delegates shall be entitled to vote on amendments to these Bylaws on behalf of the members in accordance with Article XIII of these Bylaws. THE HOUSE OF DELEGATES SHALL ELECT THE DIRECTORS AT LARGE OF THE ACADEMY. The House of Delegates shall be solely responsible for establishing such rules of procedure, which are not inconsistent with these Bylaws, the Articles of Incorporation, or existing law, as may be necessary for carrying out the activities of the House (i.e. House of Delegates Standing Rules).

ARTICLE XIII Elections.

Section 1: Positions to be Filled by Election. Elected positions include Directors-at-large; one Student Director; the Academy Officer positions of President-elect and Secretary-Treasurer; and the House Officer positions of Speaker, First Vice Speaker, and Second Vice Speaker; and such number of members of the Nominating Work Group as may be set forth in Article XI of these Bylaws. The House Officer positions shall be filled by the House of Delegates in the manner prescribed by Article VI, Section 3. THE DIRECTORS AT LARGE SHALL BE ELECTED BY THE HOUSE OF DELEGATES IN ACCORDANCE WITH THIS ARTICLE. The Student Director shall be elected in the manner prescribed by Article V, Section 3. The Nominating Work Group positions shall be filled by the House of Delegates in the manner prescribed by Article XI. All other elected positions shall be filled in the manner prescribed by this Article XIII.

Section 5: Time of Elections. The time of House Officers' elections is prescribed in Article VI, Section 3. THE ELECTION OF THE DIRECTORS AT LARGE WILL OCCUR AT THE TIME OF THE HOUSE OFFICER ELECTIONS. The Governance Commission shall determine the timing of elections of all other positions, in accordance with the requirements of these Bylaws.

Section 6: Eligibility of Voters. ELIGIBLE VOTERS FOR ACADEMY OFFICERS ARE FELLOW MEMBERS. For all positions other than the Student Director, DIRECTOR AT LARGE, House Officer, and Nominating Work Group positions, eligible voters are fellow members listed on the Academy membership roster as of the date that is thirty (30) days before the election.

ELIGIBLE VOTERS FOR DIRECTORS AT LARGE SHALL BE THE CREDENTIALED FELLOW DELEGATES AT THE TIME OF THE ELECTION.

DELEGATES FOR THE STUDENT ACADEMY SHALL NOT BE ELIGIBLE TO VOTE FOR DIRECTORS AT LARGE.

Section 7: Election Procedures. The Governance Commission shall determine the procedures for the election of Academy Officers ~~and Directors-at-large~~, including the dates for distribution and return of ballots, subject to the requirements of the North Carolina Nonprofit Corporation Act. Voting shall be by mail or electronic ballots. The Academy staff shall manage the ballot distribution. THE GOVERNANCE COMMISSION SHALL DETERMINE THE PROCEDURES FOR THE ELECTION OF DIRECTORS AT LARGE. The procedures for electing the House Officers are prescribed in Article VI, Section 3; and the procedures for electing the Student Director are prescribed in Article V, Section 3; and the procedures for electing members of the Nominating Work Group shall be determined by the House of Delegates in accordance with Article XI, Section 2.

Section 9: Commencement of Terms. The term of office for all elected positions, including Directors-at-large, the Student Director, Academy Officers, and House Officers, shall begin on June 10. In the event that the election of the House Officers AND/OR DIRECTORS AT LARGE occurs later than June 10, the new House Officers AND/OR DIRECTORS AT LARGE will take office at the close of the meeting during which they were elected.

2012-A-05 – Adopted as Amended (AAPA Board of Directors ratified the amendment)

Amend AAPA Bylaws Article XIII, Elections, Section 3 as follows:

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

a. A candidate must be a fellow member of the AAPA.
b. A candidate must be a member of an AAPA Chapter.
c. A candidate must have been an AAPA fellow member for the last three years.
d. A candidate must have accumulated at least three distinct years of experience in the past five years in at least two of the following major areas of professional involvement. THIS EXPERIENCE REQUIREMENT WILL BE WAIVED FOR CURRENTLY SITTING AAPA BOARD MEMBERS WHO CHOOSE TO RUN FOR A SUBSEQUENT TERM OF OFFICE:
    i. An AAPA or constituent organization officer, board member, committee, council, commission, work group, or task force chair
    ii. A delegate or alternate to the AAPA House of Delegates
    iii. A BOARD MEMBER**, TRUSTEE,** OR COMMITTEE CHAIR OF THE PA Foundation, Society for the Preservation of Physician Assistant History, American Academy of Physician Assistants Political Action Committee ~~trustee or committee chair~~, **PHYSICIAN ASSISTANT EDUCATION ASSOCIATION** or National Commission on Certification of Physician Assistants.
    iv. AAPA board appointees.

2012-A-06 – Adopted as Amended (AAPA Board of Directors ratified the amendment)

Amend AAPA Bylaws ARTICLE XI Nominating Work Group, Section 3, Eligibility and Qualifications as follows:

Section 3: Eligibility and Qualifications. Nominating Work Group members may not run for any of the positions they are evaluating for the upcoming election. Additionally:

a. A candidate must be a fellow member of the AAPA.
b. A candidate must have been an AAPA fellow member for the last five years.
c. A candidate must have accumulated at least ~~five~~ THREE distinct years of experience in the past ~~seven~~ FIVE years in at least two of the following major areas of professional involvement:
    i. An AAPA or constituent organization officer, board member, committee, council, commission, work group, or task force chair
    ii. A delegate or alternate to the AAPA House of Delegates
    III. PA Foundation, Society for the Preservation of Physician Assistant History, **PHYSICIAN ASSISTANT EDUCATION ASSOCIATION** or American Academy of Physician Assistants Political Action Committee trustee**, BOARD MEMBER** or committee chair
    iv. AAPA board appointees.
d. Any calendar year or Academy year in which the candidate served in more than one area of professional involvement shall be counted as one distinct year of experience.
e. With the exception of the board-appointed members, a Nominating Work Group member cannot hold any other elected office or commission or work group position in the AAPA during the time of service on the Nominating Work Group.

2012-B-01 – Divided

Amend policy HP-3200.4.2 and the attached position paper *Flexibility as a Hallmark of the PA Profession* as follows:
AAPA is opposed to specialty certification and to the use of specialty examinations that could reduce the profession's versatility and flexibility and drastically alter its value to society.

~~AAPA supports efforts by the NCCPA to explore focused, practice-specific modules, provided that recertification remains generic.~~

~~Every effort must be made to prevent regulators, employers, third-party payers, and others, including PAs from misusing the exam results.~~

See: ***Flexibility as a Hallmark of the PA Profession: The Case Against Specialty Certification*** (PP tab 20)

2012-B-01-A – Adopted as Amended

Amend by substitution policy HP-3200.4.2 as follows:

AAPA is opposed to specialty certification, the use of specialty examinations and certificates of added qualification that could reduce the profession's versatility and flexibility, drastically altering its value to society.

Every effort must be made to prevent regulators, employers, third-party payers, and others, including PAs from misusing specialty certification, the use of specialty examinations and certificates of added qualification.

2012-B-01-B – Adopted as Amended

Amend by substitution the position paper entitled *Flexibility as a Hallmark of the PA Profession: The Case Against Specialty Certification*

Flexibility as a Hallmark of the PA Profession:

The Case Against Specialty Certification

(Adopted 2002 and reaffirmed 2007)

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 is opposed to specialty certification and to the use of specialty examinations that could reduce the profession's versatility and flexibility, thus drastically altering its value to society.~~
- AAPA IS OPPOSED TO SPECIALTY CERTIFICATION, THE USE OF SPECIALTY EXAMINATIONS AND CERTIFICATES OF ADDED QUALIFICATION THAT COULD REDUCE THE PROFESSION'S VERSATILITY AND FLEXIBILITY, DRASTICALLY ALTERING ITS VALUE TO SOCIETY.

- Regulators, third party payers, employers, credentialing offices and others could misuse such SPECIALTY CERTIFICATION, THE USE OF SPECIALTY EXAMINATIONS AND CERTIFICATES OF ADDED QUALIFICATION to create artificial barriers to practice, decrease flexibility, increase costs and fragment the profession. These potential consequences and their professional implications are astounding and contrary to the hallmarks of the profession.

Introduction

Physician assistants (PAs) have worked in specialty practice from the earliest days of the profession. Debate has been ongoing about WHETHER THERE SHOULD BE recognition of specialty PRACTICE OF physician assistants, ~~the lack of~~ formal specialty credentials, and the fairness of the generalist recertification examination. ~~From time to time,~~ OVER THE YEARS, specialty certification has been proposed as the solution. ~~With t~~This paper~~, the American Academy of Physician Assistants~~ states the arguments for and against specialty certification and concludes that such a system ~~would not be~~ IS NOT in the best interests of PAs, ~~their~~ physician**S**, or the public. ~~The AAPA supports the efforts of the National Commission on Certification of Physician Assistants (NCCPA) to explore the use of practice-focused modules as part of the recertification process, provided that recertification remains generic.~~

Value of Physician Assistants

The creation of the PA profession was a significant accomplishment. After ~~conceiving the idea~~ REALIZING that the problem of physician shortage and maldistribution OF MEDICAL SERVICES could be resolved by using medically trained providers THAT work~~ing~~ with supervision, physicians developed educational curricula and programs, established accreditation and certification structures, and proposed a regulatory framework for physician assistant practice. The men and women involved in the founding of the profession, not only physicians, but also public policy experts, researchers, educators, AND lawmakers~~, and others~~ had an opportunity to take the best and most workable ideas and assemble a new model. By choice, they designed a provider who could be educated relatively quickly and inexpensively, who had generalist medical training and the skills for life-long learning, and who was flexible enough to meet THE changing societal needs.

By virtually any standard, the experiment has been a RESOUNDING success. Physician assistants have become a valuable component of health care delivery. They possess a combination of attributes not found in ~~many~~ other professions. Among the unique attributes of PAs are the focus, content, and length of their education, their socialization, AND THEIR ~~flexibility, and~~ ADAPTABILITY IN THE delivery of medical services previously provided only by physicians. PAs are also distinguished by their commitment to practic~~ing~~E as part of physician-PA ~~directed~~ teams.

PA Education

Physician assistant educational programs provide a broad-based generalist medical education with a focus on primary care.[1] PAs are trained to think like physicians and to be life-long learners. The educational process FREQUENTLY draws upon the prior experience of students, adds intense didactic and clinical instruction, and produces individuals who know how to practice MEDICINE as part of a team and value their role in the system. Their generalist training prepares PAs to work with physicians in any specialty. Similar in curriculum to the fast-track training of generalist physicians during World War II, PA programs average 27~~6~~ months in length AFTER COLLEGE PRE-REQUESITE COURSEWORK.[2] This is a relatively short production pipeline that can respond quickly to ~~changes in the size and composition~~ THE NEEDS of the health workforce.

Compared to medical school and residency training, PA education is less expensive and more quickly completed. It produces a medically-trained health care professional with significantly less educational debt. A physician assistant is available to join the health workforce and increase patient access to care in fewer years than it takes to produce other medical providers.

Unlike advanced practice nurses, who attend specialty -specific nursing programs, PAs have a general~~, primary care,~~ medical background DESIGNED FOR THE PRIMARY CARE SETTING. By virtue of the broad foundation of PA education, future employment is not limited to one specialty. Graduates who wish to increase their skills and knowledge in a particular specialty may do so through a clinically based postgraduate program, ~~a less structured series of~~ workshops and continuing medical education sessions, additional clinical training in the practice setting, or a combination of these

options. It is the PA's decision whether THEY WISH TO PURSUE THIS and how to obtain additional training.

PA Practice

By functioning as part of physician-directed teams, PAs have flexibility in practice. A supervising physician is ~~free,~~ ~~ALLOWED~~ AUTHORIZED within the boundaries of state law OR FEDERAL REGULATIONS, to delegate to the PA any portion ~~of his services~~ OF THE PHYSICIAN'S PRACTICE that are within the PA's ability to perform.[3] New tasks and responsibilities can be taught and delegated as the PA's expertise expands and as the team members' understanding of one another grows. A physician assistant may choose to change specialties or may practice in more than one specialty simultaneously.

There are benefits to society from having a well-educated, flexible, and cost effective medical provider as part of the workforce. PAs fill a role that CANNOT BE FILLED BY other providers ~~cannot fill~~. For example, community-based training, a broad set of primary care skills, and lower salary expectations enable PAs to meet patient needs in poor and underserved areas that cannot afford to support a physician full-time. PAs also add value to the public's investment in the education of physicians by freeing physicians from routine responsibilities, allowing them to ~~deal with~~ TREAT patients whose complex medical conditions require their expertise and to expand the services offered by their practices. The synergy of physician-PA team practice benefits patients both individually and collectively.

Physicians have a depth and breadth of training that is unmatched by other medical professionals. PAs embrace the notion that physicians should lead the health care team. PAs do not seek to compete with physicians, but rather endorse their role and support the concept of physician-directed care.

The current system THAT CONSISTS OF education, NATIONAL certification, STATE licensure, FEDERAL REGULATIONS and THE team practice CONCEPT has made this success possible. THE AAPA BELIEVES THAT Changes to the system should be made only if they are improvements that have benefits for the public as well as for PAs and their physician colleagues.

A System in Flux

DRAMATIC CHANGES ARE OCCURRING IN THE HEALTH CARE SYSTEM. ~~Managed care has drastically altered the health care marketplace. The growing role of administrators and accountants, with their focus on the bottom line and the interests of investors, has led to decreased autonomy for physicians and other providers. The rising cost of health care has made it essential to institute money-saving measures, sometimes reflected in a reduction of nursing staff or other provider positions. The percentage of the Gross Domestic Product spent on health care continues to rise, reflecting growing demand for services. Competition among managed care organizations (MCOs) has increased, leading to mergers of large corporations and further elimination of duplicative positions. The aging of the population adds another set of pressures to the marketplace. These competing forces combine to create an atmosphere of change and uncertainty.~~ THE UNCONTROLLED RISES IN THE COST OF HEALTH CARE HAS MADE IT ESSENTIAL TO INSTITUTE COST-SAVING MEASURES. THE PERCENTAGE OF THE GROSS DOMESTIC PRODUCT SPENT ON HEALTH CARE CONTINUES TO RISE, REFLECTING NOT ONLY A GROWTH IN SERVICE DEMANDS, BUT ALSO EXEMPLIFYING A POOR HEALTHCARE DELIVERY SYSTEM. WITH THE PASSING OF HEALTHCARE REFORM, THERE WILL BE A CONTINUED PUSH TO REDUCE COSTS BY ELIMINATING DUPLICATIVE SERVICES, IMPROVING QUALITY AND EFFICIENCY OF THE DELIVERY OF CARE, AS WELL AS A NEW FOCUS ON INCREASING PRIMARY CARE PROVIDERS. ALTHOUGH THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AIMS TO ENSURE THAT ALL AMERICANS HAVE ACCESS TO QUALITY, AFFORDABLE HEALTH CARE AND TO CREATE THE CHANGES WITHIN THE SYSTEM TO CONTAIN COSTS, THIS MUST BE BALANCED WITH A LARGE AGING POPULATION AND A CURRENT SHORTAGE OF PRIMARY CARE PROVIDERS. THESE COMPETING FORCES COMBINE TO CREATE AN ATMOSPHERE OF CHANGE AND UNCERTAINTY WITHIN HEALTHCARE.

~~The global shifts in the economy are beyond the control of any one group, but it is possible for PAs to make decisions that are specific to the profession, such as the means by which PAs affirm their continued proficiency or obtain recognition of achievements in specialty practice. It is critical to make these decisions within the context of the changing~~

~~marketplace and with the public good in mind.~~ ALTHOUGH GLOBAL SHIFTS IN THE ECONOMY ARE BEYOND THE CONTROL OF ANY ONE GROUP, IT IS IMPORTANT TO REMEMBER THAT PAS ARE ABLE TO MAKE IMPACTFUL DECISION ABOUT THE PROFESSION WITHIN THESE SHIFTS. AN EXAMPLE OF THIS IS DETERMINING THE MEANS BY WHICH PAS AFFIRM THEIR CONTINUED PROFICIENCY OR OBTAIN RECOGNITION OF ACHIEVEMENT WITHIN THEIR SPECIALTY PRACTICE. IT IS CRITICAL TO MAKE THESE DECISIONS WITH THE CONTEXT OF THE CHANGING MARKETPLACE AND WITH THE PUBLIC GOOD IN MIND. THE PA PROFESSION MUST REMAIN AS DYNAMICALLY FLUID AS THE HEALTHCARE SYSTEM IN WHICH PAS PRACTICE.

Specialty Practice

There have been PAs in specialty practice ~~from~~ SINCE the beginning of the profession. Two of the first four PA graduates from the original Duke University program chose non-primary care fields in which to practice and today approximately half of PAs are in specialty practices.[4] The growing number of specialty PA organizations attests to the interest and employment opportunities for PAs in specialties and to the interest of specialty physicians in PAs.

However, PAs in specialty practice have identified several issues of concern. When faced with employment opportunities in a particular specialty, some PAs with experience in that specialty have said THAT they need a credential other than THE ~~NCCPA~~ NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS (NCCPA) certification to demonstrate their expertise and ADVANCED SKILL LEVEL;~~,~~ a credential that C~~w~~ould make them more attractive than experienced PAs new to the specialty or new graduate PAs~~s willing to work for a lower salary~~. PAs employed by some government agencies and institutional employers point out that they need additional qualifications in order to move up the career ladder and obtain promotions or salary increases. LASTLY, THERE ARE Some PAs who have practiced in specialties for many years WHO have expressed a desire for recognition of their accomplishments.

One solution that has been discussed is specialty board certification, similar to that held by physicians.

The ~~idea~~ CONCEPT of specialty boards REQUIRES COLLABORATION WITH THE NCCPA. ~~naturally brings into the discussion the c~~CurrentLY THE NCCPA'S certification process~~, which~~ tests new graduates by means of an initial certifying examination, known as THE PANCE (Physician Assistant National Certifying Examination) and re-tests practicing PAs every six years by means of a generalist recertification examination KNOWN AS THE ~~(~~PANRE~~,~~ or (Physician Assistant National Recertification Examination) ~~or the alternative mechanism of Pathway II~~. Since 1973 the PANCE has served as ~~a de facto licensing~~THE CERTIFICATION examination for ALL PAs. PASSAGE OF THE NCCPA'S PANCE EXAMINATION IS REQUIRED IN ALL STATES IN ORDER TO OBTAIN LICENSURE TO PRACTICE.

The current system is economical and efficient and enhances the flexibility and value of PAs to society, but the generalist recertification examination has troubled PAs whose practice is concentrated in a specialty or subspecialty area. ~~Because of~~DUE TO the close working relationship between PAs and physicians, it is reasonable to examine the physician certification model to see if it would be workable for PAs.

Both medical school and PA programs educate their students in general medicine. After graduation, physicians enter residency training programs in the specialty of their choice. Upon completion ~~of one or more years~~ of residency, physicians take A certif~~ying~~ICATION exam~~inations~~ produced by specialty boards. Although postgraduate training is a prerequisite for licensure, board certification CURRENTLY is not IN MOST JURISDICTIONS, nor is the absence of board certification an obstacle to practice once licensure has been obtained.

The physician assistant educational process does not include mandatory postgraduate residencies, nor does it include specialty certification examinations. A discussion of the advantages and disadvantages ~~of following the physician model~~ of specialty certification is presented below.

<u>Advantages of Specialty Certification</u>

There ~~may be many~~ ARE advantages to specialty certification. It implies added knowledge, qualifications, or skills. In American society, individuals with outstanding accomplishments frequently receive awards, prizes, honorary titles, ~~or~~ AND certificates. A document is awarded to providers who complete training courses in particular clinical skills, such as endoscopy or colposcopy. ~~Some a~~Advocates of specialty certification

believe an additional credential attests to THEIR experience and achievement in a specialty field of practice.

To the public and employers, specialty certification may provide a sense of reassurance. ~~Given the general public's incomplete understanding~~ AS THE GENERAL PUBLIC MAY NOT UNDERSTAND THE EDUCATION of the PA ~~profession,~~ AND THEIR FLEXIBILITY, another credential may enhance the credibility of the PA. Employers, including physicians accustomed to the specialty boards of their own profession, may have an added sense of comfort. The administrative personnel in large institutions, particularly those in charge of credentialing the medical staff, may also recognize specialty certification as something familiar, akin to the physician model.

Consequently, the result for specialty certified PAs may be increased employment opportunities, greater job security, and enhanced compensation. Specialty certification also has the potential to simplify the process by which institutions ~~or managed care organizations~~ grant clinical privileges OR PAYERS REIMBURSE. ~~It could even provide PAs with a competitive edge over other non-physician providers, such as advanced practice nurses or surgical assistants.~~

For PAs who need additional qualifications in order to achieve advancement ~~in a bureaucratic institution~~, WITHIN AN INSTITUTION, specialty certification may provide one step up the career ladder. Past testimony in the AAPA House of Delegates indicates that PAs who desire concrete evidence of their accomplishments would find satisfaction in a framed certificate or some other visible sign of their specialty certification.

For many, specialty certification offers the potential to reform the recertification process. Recertification could be limited to testing only the skills and knowledge needed for the PA's specialty practice. For example, PAs who have worked in otolaryngology for 25 years would not be examined on their knowledge of obstetrics. Focusing recertification on knowledge limited to THE specialty practice ~~w~~could reduce concerns about failure, particularly in light of the fact that PAs who do not successfully complete the current process lose their national certification.

<u>Disadvantages of Specialty Certification</u>

~~There are also numerous disadvantages to specialty certification. One of the most important is the limit it would place on PA flexibility, both professionally and in the~~

~~delivery of care. It would no longer be easy to change from one specialty practice to another. It could affect a PA's ability to provide care in more than one specialty at a time or to hold part-time jobs. For example, a PA working in adult cardiology might not be able to moonlight in urgent care or a PA in general surgery might not be able to cover orthopedics on an as-needed basis without certification in that specialty.~~

~~The immediate result of specialty certification could be a multi-tiered job market in which PAs without the extra credentials would be at an economic and professional disadvantage. This could manifest itself in terms of employment opportunities, salaries, professional liability, and coverage of services by third party payers. To remedy the situation, PAs could undertake additional education, but currently there are limited opportunities for formal specialty training. Pursuing postgraduate training in more than one specialty would be time-consuming and expensive.~~

~~There are many unanswered questions regarding maintenance of specialty credentials and the consequences of failing a specialty certification examination, including the impact on hospital privileges and professional liability insurance premiums.~~

~~Licensing boards and other regulatory authorities have frequently tried to manage the physician-PA team at an inappropriate level of detail. Given the opportunity to require specialty certification, it is likely that some states would make it a prerequisite for licensure or for approval of a specific delegated scope of practice. This could complicate the requirements for supervision. Regulators might decide that specialty certified PAs could only be supervised by board-certified physicians with matching credentials. This could adversely affect the day-to-day practice of PAs in large, multi-specialty groups and create a disincentive to employ them. The absence of certification for PAs in a particular specialty could prevent PAs from working in that field. Failure to maintain specialty certification could result in a restricted scope of practice or, in a worst case scenario, loss of licensure.~~

~~There are also questions about the timing of specialty certification. Would it be awarded soon after graduation or after a specific period of time? Would formal training be required? If not, what competencies would be evaluated, given the non-standardized variety of experiences to which PAs are subject? Unlike physicians, who move through a highly structured education and examination process at the beginning of their careers, PAs obtain their expertise in specialties through many different routes.~~

~~Educators would be wise to ask what impact specialty certification might have on entry-level PA education. It would be tempting for programs to revise their curricula and become specialty-oriented, or to increase their length, thus adding to the cost of training One should also look at the potential for a proliferation of postgraduate programs and, aside from the current lack of national standards and accreditation, ask if the capacity exists and whether more time spent in hospital-based training is what the profession should bring to the health care system.~~

~~Some of the other arguments in favor of specialty certification can also be debated. Another certificate on the office wall or another set of letters behind a PA's name may not reassure patients or help them better understand the role of a PA. Employers may not understand and value specialty certification in a way that assures hiring preferences, higher pay, and automatic awarding of hospital privileges.~~

~~Questions that are raised now about the generalist recertification examination carry over to specialty recertification. What core knowledge would be tested? Practice activities can be as diverse within a specialty as they are across specialties. For example, a surgical PA may act as a first assistant, do hospital rounds, or see patients in an office setting. A PA working in cardiology may concentrate on patients in the ICU or manage outpatient care. Difficult decisions would have to be made regarding the spheres of specialty knowledge that would be encompassed in an examination in order to develop a specialty recertification instrument that did not draw criticism from sub-specialists.~~

~~All of these are valid concerns, but in truth the larger questions are these: If it takes longer and becomes more expensive to train PAs, is the benefit worth the cost to society? Will PAs remain flexible and responsive to changing patient and workforce needs? Will they retain their unique attributes?~~

~~One of the hallmarks of the PA profession is its flexibility. Specialty certification would undermine this flexibility, or at best make it extremely difficult to achieve. Locking PAs into specialty practice by means of certification would have an impact on all PAs, not only those in specialty practice. Specialty certification would cause a cultural shift for the profession, making specialization mandatory, rather than voluntary. Some of the dissatisfaction now experienced by specialty PAs would shift to the other half of the profession, those who embrace generalist primary care and chose the profession for its broad vision and practice possibilities. Resolving the employment and legal problems~~

~~associated with initiation of specialty certification would require the expenditure of much time, money, and political capital.~~

~~Moreover, resources used to obtain additional training translate to additional costs for patients, since training costs and potentially higher salaries would be passed along to consumers. American health care expenditures already exceed those of other countries, making it difficult to justify increased costs to sustain a specialty certification system.~~

~~Although few could argue against making specialty care available in underserved areas, the deployment of PAs may become less economically feasible. Individuals who have incurred additional education-related debts, or who have become accustomed to tertiary care practice settings may be reluctant to work with fewer resources in rural or urban underserved communities. Regulatory restrictions associated with a rigid specialty certification system may also hinder deployment.~~

~~The PA profession was created to increase access to care. In many cases, it has done so by extending primary care physician services to patients in underserved areas. It has also done so by filling niche markets as the health care system changes. PAs frequently change practice settings and specialties in response to these opportunities. Imposing a specialty certification system has the potential to eliminate many of the values that PAs bring to society.~~

~~Specialty certification would not be a panacea for PAs seeking to add qualifications in order to advance up a career ladder. It is presumably a step whose benefit can be realized only one time. Given the consequences to the profession as a whole, specialty certification is too drastic a solution to a problem faced only by PAs in certain employment settings, such as those working for the Department of Veterans Affairs, the military, or academic institutions.~~

~~An alternate approach to the problem is the one that many PAs currently pursue. It includes academic coursework, advanced degrees, and training workshops that enhance one's ability to perform certain procedures. These options may improve a PA's marketability. The Academy recognizes, however, that further work may need to be done to address this particular problem.~~

THERE ARE ALSO DISADVANTAGES TO SPECIALTY CERTIFICATION FOR PAS. THE MOST COMPELLING IS THE LOSS OF FLEXIBILITY OF THE PROFESSION. THIS WOULD IMPACT ON THE PA AND THE ABILITY TO

WORK WITH THE PA'S PHYSICIAN COLLEAGUES AND PROVIDE THE COMPREHENSIVE DELIVERY OF HEALTH CARE NEEDED IN SOCIETY TODAY.

SHOULD THE PROFESSION EMBRACE SPECIALTY CERTIFICATION, THE IMPACT COULD BE A MULTI-TIERED PROFESSIONAL STRUCTURE. THOSE WITH SPECIALTY CERTIFICATION COULD BE AT AN ECONOMIC AND PROFESSIONAL ADVANTAGE. THOSE WITHOUT COULD MANIFEST ITSELF IN TERMS OF LOSS OF EMPLOYMENT OPPORTUNITIES, DECREASED SALARIES, INCREASED PROFESSIONAL LIABILITY AND A CHANGE IN THE COVERAGE OF SERVICES BY THE THIRD PARTY PAYER. IN SPITE OF THE FACT THAT MANY PAS WORK IN SPECIALTIES, SPECIALTY CERTIFICATION COULD PLACE THE MORE ECONOMICALLY DESIROUS OF SPECIALTIES AT THE FOREFRONT AND THE LEAST ECONOMICALLY DESIRABLE, SUCH AS PRIMARY CARE, BEHIND. THIS COULD HAVE A GRAVE IMPACT ON THE LANDSCAPE OF THE DELIVERY OF HEALTH CARE.

IN ADDITION, SPECIALTY CERTIFICATION COULD CHANGE THE CULTURE OF THE PAS. THE HALLMARK OF THE PROFESSION HAS BEEN TO FILL THE GAP AND WORK WITH THE PHYSICIAN IN PROVIDING HEALTH CARE. THE PAS FLEXIBILITY AND ABILITY TO ADAPT TO THE NEEDS OF THE HEALTH CARE COMMUNITY HAS BEEN ONE OF THE ASSETS OF THE PROFESSION. THERE ARE SOME PAS WHO ELECT TO DO PRIMARY CARE AND NOT EMBRACE SPECIALTIES. THEY SHOULD NOT BE PENALIZED.

THE EDUCATION OF PAS COULD ALSO BE AFFECTED. CURRENTLY, THE FOCUS OF THE EDUCATION OF PA STUDENTS IS TOWARDS PRIMARY CARE, THUS ALLOWING THE GRADUATE THE FREEDOM OF CHOICE TO CHOOSE WHERE THEY WANT TO WORK. THE LACK OF SPECIALTY TRAINING COULD LIMIT THEIR JOB OPPORTUNITIES AND THUS PLACE PRESSURE ON THE EDUCATIONAL INSTITUTION IN PROVIDING SPECIALTY EDUCATION TO THE STUDENTS. THE ACCREDITATION REVIEW COMMISSION ON PHYSICIAN ASSISTANT EDUCATION (ARC-PA) IS REPLETE IN ITS REQUIREMENTS THAT MUST BE INCLUDED IN THE CURRICULUM. ADDING A TRACK FOR SPECIALTY TRAINING COULD BE ARDUOUS AND

MAY EXTEND THE TIME OF THE PROGRAM, AS WELL AS TUITION FEES. ONE OF THE ADVANTAGES OF ATTENDING PA SCHOOL IS THE TIME AND FINANCIAL COMMITMENT THAT IS LESS THAN ATTENDING MEDICAL SCHOOL. THIS COULD REQUIRE A COMPLETE RESTRUCTURING OF THE ARC-PA REQUIREMENTS FOR PA EDUCATION AND MAY HAVE ADMISSION CANDIDATES THINKING TWICE ABOUT APPLYING TO PA SCHOOL.

SPECIALTY TRAINING COULD ALSO HAVE AN IMPACT ON HOW THE LICENSING BOARDS LICENSE PAS. SHOULD THERE BE SPECIALTY CERTIFICATION, STATE STATUTES AND REGULATIONS COULD REQUIRE PAS TO ACHIEVE SPECIALTY TRAINING, WHETHER IT IS IN NEURO-SURGERY OR PRIMARY CARE. THIS COULD IMPACT THE PA WHO WISHES TO MOVE FROM EMERGENCY MEDICINE TO PEDIATRICS. ADDITIONALLY, LEGISLATORS AND ADMINISTRATORS MAY CONFUSE SPECIALTY CERTIFICATION WITH OTHER CERTIFICATION EXAMINATIONS SUCH THE ORTHOPEDIC PHYSICIAN'S ASSISTANTS (OPA) AND ANESTHESIOLOGIST'S ASSISTANT (AA). REGULATORS, THIRD PARTY PAYERS, EMPLOYERS, CREDENTIALING OFFICES, AND OTHERS CAN MISUSE SUCH TESTS TO CREATE ARTIFICIAL BARRIERS TO PRACTICE, DECREASE FLEXIBILITY, INCREASE COSTS, AND FRAGMENT THE PROFESSION. THE PROFESSIONAL IMPLICATIONS ARE ASTOUNDING AND ARE CONTRARY TO HALLMARKS OF THE PROFESSION.

Specialty Examinations

~~The NCCPA president has said that the organization is committed to generalist certification and has no plans to develop specialty certification.[5] The Commission is investigating the feasibility of examining PAs in "focused areas of practice." [5] By this, the NCCPA means separate components, or mini-exams, on pediatrics, surgery, obstetrics, emergency medicine, cardiology, etc., a combination of which could be chosen by the person taking the recertification examination.~~ THE NCCPA HAS BEEN ~~**ACTIVE IN**~~ ADDRESSING THIS COMPLEX ISSUE. ALTHOUGH IT STILL EMBRACES THE PRIMARY CARE CONCEPT AS EVIDENCED IN THE PANCE AND PANRE, IT HAS, HOWEVER, IMPLEMENTED CERTIFICATES OF ADDED QUALIFICATION **(CAQ),** SPECIALTY EXAMINATIONS. THE SPECIALTIES

CURRENTLY INCLUDED IN THE CAQ PROJECT ARE EMERGENCY MEDICINE, ORTHOPEDIC SURGERY, CARDIOVASCULAR AND THORACIC SURGERY, NEPHROLOGY AND PSYCHIATRY. SUCCESSFUL COMPLETION OF THE CAQ REQUIREMENTS ALLOWS THE PA TO OBTAIN AN ADDED CREDENTIAL ~~OF~~ ~~EXPERTISE~~ IN THE SPECIALTY.

PROMOTING SPECIALTY CERTIFICATION EXAMINATIONS ONLY ENHANCES THE CONCEPT OF SPECIALTY CERTIFICATION AND DIMINISHES THE GENERALIST VALUE OF THE PA PROFESSION.

~~The American Board of Family Practice uses this model. As part of the recertification process, family physicians take a core examination and also may choose from a number of elective components. If successful, they retain their family practice diplomate status. No information is released indicating which particular aspects of practice (obstetrics, pediatrics, behavioral medicine, etc.) were tested.~~

~~There is no question about the need to evaluate the knowledge of PAs in a broad range of medical areas. No one can say that pediatrics, surgery, geriatrics, and other topics should not be included in an initial certification examination or in a generalist recertification examination. But the knowledge tested in any new modules must be relevant to all PAs. And great care must be taken so that the modules are not extracted to become stand-alone specialty examinations. Care should also be taken to discourage or prevent the reporting of passage of these components in a fashion that could be misinterpreted or misused as a specialty credential. The objections raised to specialty certification also apply to specialty examinations. Regulators, third party payers, employers, credentialing offices, and others can misuse such tests to create artificial barriers to practice, decrease flexibility, increase costs, and fragment the profession.~~

~~Specialty examinations also offer the potential for competition among professional testing organizations. Certification examinations are currently offered to orthopedic physician's assistants (OPAs) and to anesthesiologists' assistants (AAs) by testing organizations other than the NCCPA. Both OPAs and AAs have sought legal recognition as PAs, claiming their education and certification standards are equivalent to those of the PA profession. On occasion, and through ignorance, employers and regulators have been misled by these groups into believing that their training and qualifications are equivalent. The fact that PAs have one national set of standards for~~

~~their generalist education and certification has been a strong, politically effective argument for acceptance and progress. The confusion that could arise by blurring the lines between PAs and other non-physicians would not be to the advantage of PAs or the public.~~

Conclusion

The American Academy of Physician Assistants HIGHLY values ~~highly~~ the contributions of physician assistants in all areas of practice. It believes strongly in the mission of the profession, which is to promote quality, cost effective, and accessible healthcare, and concludes that this mission can best be met if PAs have the flexibility to adapt to changes in the health care workforce and market. Therefore, the AAPA is opposed to specialty certification and to the use of specialty examinations that could reduce the profession's versatility and flexibility**,** ~~and~~ THUS drastically alterING its value to society. ~~The AAPA supports efforts by the NCCPA to explore focused, practice-specific modules, provided that recertification remains generic. Every effort must be made to prevent regulators, employers, third party payers, and others including PAs – from misusing the exam results.~~

References

1. Accreditation Standards for Physician Assistant Education. ARC-PA. SEPTEMBER, 2010~~January 2001~~.

2. ~~16th~~ 24th Annual Report on Physician Assistant Educational Programs in the United States,

2007-2008 ~~1999-2000~~. PAEA. Alexandria, VA. 2008~~June 2000~~.

3. Physician Assistants: State Laws and Regulations. AAPA, Alexandria, VA. 2011~~00~~.

4. 2010 AAPA Physician Assistant Census Report. AAPA, Alexandria, VA. 2011~~October 2000~~.

2012-B-02 – Adopted as Amended

AAPA defines the following positions as officers of a Constituent Organization: President, President-elect, Vice President, Secretary and Treasurer, and/or Secretary-Treasurer.

This definition is for AAPA policy purposes and does not require any organization to have a particular office.

2012-B-03 – Adopted as Amended

Amend policy HX-4600.3.4 as follows:

AAPA urges all federal, state, local and privately funded programs to include and recruit physician assistants in all healthcare scholarship and loan repayment programs.

2012-B-04 – Adopted

The AAPA recommends that every Constituent Organization include a federal liaison position on their Government Affairs Committee or comparable body to coordinate national PA legislative efforts.

2012-B-05 – Adopted on Consent Agenda

Reject referred 2011-B-06 entitled *Statement on PA to MD/DO "Bridge Programs."*

2012-B-06 – Adopted

Amend by substitution policies HP-3500.3.3, Guidelines for Amending Medical Staff Bylaws, and HP-3500.3.5, Guidelines for Privileging Physician Assistants with the position paper entitled "Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging Physician Assistants." See position paper below.

Guidelines for Updating Medical Staff Bylaws:

Credentialing and Privileging Physician Assistants

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 that

- Physician assistants must seek delineation of their clinical privileges and that the process must be outlined in medical staff bylaws.
- Physician assistants should be members of the medical staff.
- Medical staff bylaws should require that each physician assistant be granted clinical privileges regardless of whether the PA is an employee of a practice or of the hospital.
- The criteria for delineating PA clinical privileges should be specified in the bylaws.
- AAPA opposes specialty certification examinations as a requirement for physician assistant credentialing or privileging.
- Duration of appointments and privileges should be the same for physicians and physician assistants.
- Bylaws should give physician assistants the right to due process when actions taken by the medical staff or governing board adversely affect his or her clinical privileges.

- The criteria and process for disciplining physician assistants should be spelled out in the bylaws. The process should involve PA peers and conform to the process applied to physicians
- Bylaws should provide mechanisms to carry out quality assurance with respect to PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the same area of clinical specialty.
- Bylaws should require PA participation in continuing medical education that relates to their practice and their privileges.
- Bylaws should allow PA representation on medical staff committees, including the medical executive committee.
- Bylaws should include language enabling physician assistants to provide care during emergency or disaster situations.

Introduction

Physician assistants (PAs) are highly skilled professionals who practice in every medical and surgical specialty. They are employed by hospitals and healthcare systems, medical practices, hospital medicine groups, and emergency department staffing groups. PAs provide medical care almost anywhere in a hospital, including emergency departments, inpatient services, operating rooms, outpatient units and critical care/intensive care units. Requirements for PA practice are defined by state law and hospital policy. All state laws allow the flexibility of physicians being off-site as long as they are available via telecommunication. Most hospitals develop policies and definitions based on the language used in their state's laws and regulations governing PA practice. Federal facilities and federally employed PAs, however, are governed by federal agency guidelines, not state law.

The criteria and process for granting clinical privileges to physician assistants is similar to the process for physicians and must be outlined in the medical staff bylaws. The organized medical staff is required to review and verify the credentials of practitioners to ensure that those who provide medical care are competent and qualified to provide specified levels of care. In order to provide patient care services in the hospital or other healthcare facilities, physician assistants must seek delineation of their clinical privileges, which are then granted by the medical staff, and ultimately, the governing body.

In most hospitals, the medical staff credentialing process involves simultaneous consideration of applications for medical staff membership and for clinical privileges. The following guidelines are intended to assist medical staffs in making appropriate changes to the bylaws that authorize the granting of membership and clinical privileges to physician assistants. They are intended to be a general guide that can be applied and adapted to suit the requirements of individual medical staffs. Where possible, sample language has been included.

Definition of Physician Assistant

Medical staff bylaws usually begin with a section that includes definitions of terms. This section should include a definition of physician assistant. It should generally conform to the definition used in state law and may reflect the definition used by the American Academy of Physician Assistants. In the case of federally employed PAs, the legal definition is found in federal regulations or policies, rather than state law.

All states [1] require that a physician assistant

- be a graduate of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies and/or
- pass the initial exam given by the National Commission on Certification of Physician Assistants (NCCPA),
- be licensed to practice as a physician assistant.

Federally employed PAs must meet the first two criteria, but are typically not required to be licensed, as federal agencies are not governed by state laws. Many states and employers require current NCCPA certification. [2]

The following definition serves as an example.

~~A **physician assistant** (PA) is an individual who is a graduate of a physician assistant program approved by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies, and/or has been certified by the National Commission on Certification of Physician Assistants (NCCPA). The individual meets the necessary legal requirements for licensure to practice medicine as delegated by a licensed physician.~~

PAs as Members of the Medical Staff

AAPA believes that physician assistants should be members of the medical staff. Physician assistants are providers of a broad range of services that otherwise would be performed by physicians. They exercise a high level of decision-making and autonomy in providing patient care as members of medical and surgical teams. Medical staff privileges enable/authorize clinicians to diagnose illness and perform other functions in the hospital. Medical staff "membership" is not a pre-requisite for a hospital to grant physicians or PAs clinical privileges. However, medical staff membership allows PAs a voice in developing and implementing hospital and medical staff policies and ensures participation in programs to review the quality and appropriateness of patient care. It is important that PAs participate in the system in which medical care policies are made and communicated.[3]

In the majority of states, medical staff and hospital governing boards decide which types of practitioners will be medical staff members. Both the Joint Commission Medical Staff standards and Medicare's Conditions of Participation for Hospitals allow PA membership on medical staffs. The Joint Commission's Comprehensive Accreditation Manual for Hospitals states: "The governing body and the medical staff define medical staff membership criteria, which…may include licensed independent practitioners and other practitioners." The Medicare Conditions of Participation for Hospitals clearly state that, in addition to MD and DO members, the medical staff "may also be composed of other practitioners appointed by the governing body."[4] The Medicare surveyors' manual further specifies that hospitals can appoint PAs to the medical staff.[4] State law should be consulted; the makeup of medical staff membership is occasionally dictated there.[5]

Sometimes PAs are erroneously categorized as allied health professionals or under nursing structures. PAs, by definition, are providers of medical care and, as such, are not part of the allied health field or nursing profession. The National Commission on Allied Health, convened by an act of Congress in 1992, defined an allied health professional as "a health professional (other than a registered nurse or physician assistant)…." The federal Bureau of Health Professions uses this same definition and

classifies PAs as medical providers. [42USCS §295p; Title 42. The Public Health and Welfare, Chapter 6A – Public Health Services]

AAPA believes that PAs should be referred to as "physician assistants" and not combined with other providers in non-specific, inclusive terms such as "midlevel practitioner," "advanced practice clinician," or "advanced practice provider." PAs should utilize, and encourage employers (e.g., hospitals, HMO's**,** clinics), third party payers, educators, researchers, and the government to utilize, the term "physician assistant" or "PA" for clarity and accuracy.[6]

Medical staff membership language might state:

Membership on the medical staff shall be extended to physicians, dentists, podiatrists, physician assistants, and clinical psychologists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and who are appointed by the hospital Board of Directors.

Credentialing Physician Assistants

Medical staff bylaws specify professional criteria for medical staff membership and clinical privileges. The Joint Commission specifies four core criteria that should be met when credentialing licensed independent practitioners, including:

- current licensure
- relevant training or experience
- current competence and
- the ability to perform privileges requested.

This serves as a reasonable guideline. As applied to physician assistants, these criteria might include:

- evidence of national certification
- letters from previous employers, supervising physicians, physician assistant peers, or PA programs attesting to scope and level of performance
- verified logs of clinical procedures
- personal attestation as to physical and mental health status
- evidence of adequate professional liability insurance
- information on any past or pending professional liability or disciplinary actions
- a letter from a sponsoring physician (MD or DO) who is a member of the medical staff.

When credentialing a PA, a query should be made to the National Practitioner Data Bank (NPDB) regarding the individual's medical liability and disciplinary histories. Entities that make malpractice payments on behalf of PAs have been required to report that information to the NPDB since its inception in 1990. Since March 2010, employers and regulators have been required to report to the NPDB adverse professional review actions taken against PAs. Queries about licensure actions taken against PAs can be made to the Federation of State Medical Boards (FSMB). Though all state licensing boards are encouraged to report disciplinary actions to the FSMB, it is impossible to ascertain whether all actions are reported, so it is important that hospitals also query individual boards in all states where the PA has been licensed.

The American Medical Association's (AMA) Physician Profile Service also offers PA credentials verification. Credentialing professionals can confirm a PA's education program attendance and graduation dates, national certification number and status, current and historical state licensure information, and AAPA membership status. The Joint Commission has deemed that the information provided by the AMA Physician Profile service is equivalent to primary source information.

Physician Assistant Privileges

The fundamental premise of the physician assistant profession is a solid educational foundation in medicine and surgery that prepares PAs to work with physicians in any specialty or care setting. The medical staff bylaws should require that each PA be granted clinical privileges regardless of whether the PA is an employee of a practice or of the hospital. Medical staff membership should not be a requirement for granting of clinical privileges. This is in accordance with Joint Commission standards and the Medicare Conditions of Participation for Hospitals.

The medical staff bylaws should stipulate that all clinical privileges granted to a physician assistant should be consistent with all applicable state and federal laws and regulations and that a physician assistant may provide medical and surgical services as delegated by a physician. Typically, privileges for a physician assistant are delineated using a form and process identical to or very similar to that used for physicians. Because PAs provide medical services, the physician form and privileging system is a useful template for developing a system of granting PA privileges.

The process for granting clinical privileges is usually discussed in four places in the bylaws: the article concerned with clinical privileges, the article describing the structure of the credentials committee, the article describing the duties of department chairs, and the article describing hearing procedures. The process of granting clinical privileges may vary considerably from one hospital to another, but generally the process should include the following: 1) completion in a timely fashion; 2) department chairs, if they exist, should make specific recommendations for clinical privileges; 3) an appeal mechanism for adverse decisions; and 4) the governing board should have ultimate authority to grant clinical privileges. An application for renewal of clinical privileges should be processed in essentially the same manner as that for granting initial privileges.

The criteria for delineating clinical privileges should be specified in the bylaws. They are usually the same as those used for credentialing: evidence of current state licensure, relevant training and experience, national certification, letters or other verification from authoritative sources attesting to the individual's ability to perform certain privileges, attestation as to physical and mental health status, evidence of adequate liability insurance, and information on any past or pending professional liability or disciplinary actions. Privilege determinations – at reappointment or other interim times – might also include observed clinical performance, quality improvement data, and other documented results of quality improvement activities required by the hospital and medical staff.

Other requirements of physician members of the medical staff also may apply to PAs. For example, if hospital policy requires that a department chair approves physician privilege requests before they are submitted to the medical staff credentials committee, then the same should apply to PAs. .For Joint Commission-accredited hospitals, PAs, like physicians, are evaluated using a focused professional practice evaluation (FPPE) for new privileges or performance improvement and ongoing professional practice evaluation OPPE) for bi-annual reappointment.

Expanding Privileges

PAs are educated in the medical model of evaluation, diagnosis, and treatment. They are committed to life-long learning through clinical experience and continuing medical education. Recognition that new tasks and responsibilities can be taught and delegated to the PA by physicians as a PA gains experience, and as the physician and PA

grow as a team, are key to effective utilization of PAs. As such, PAs may need to request additional privileges; this process should mirror as that of the physicians requesting additional privileges

Specialty and Subspecialty Privileges

When PAs request privileges for specialized procedures or other highly technical, specialty-related care, their qualifications should be assessed just as they would be for any other privilege – verification of specialized training in the clinical setting, previous privileges, relevant CME, a documented skills assessment, or performance of procedures under direct proctoring by a physician or physician assistant granted privileges to perform the procedure.

The AAPA is committed to lifelong learning and encourages advanced educational opportunities (such as Pediatric Advanced Life Support (PALS) or Advanced Trauma Life Support (ATLS)), as well as verification of specific course completion, However, AAPA does oppose specialty certification examinations as a *requirement* for physician assistant credentialing or privileging. The physician assistant profession currently does not have a system of specialty credentialing like the specialty boards system developed by physicians. Because there are other ways to assess PA competency, the AAPA believes imposing specialty boards or specialty exams is unnecessary and would undermine the basic construct of the profession, which is to be broadly educated medical providers with the versatility and adaptability to meet changing health care needs. Many PAs fulfill their national certification CME requirement by attending highly specialized courses specific to their area of practice.

Duration and Renewal of Appointments

Duration of appointments and privileges should be the same for physicians and physician assistants. The renewal/re-appointment process should also be aligned with that required of physicians.

Due Process

The bylaws should give the physician assistant 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 clinical privileges. Hospital accreditation standards from the Joint Commission specifically state that medical staffs must establish a fair hearing and

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

Corrective Action

The criteria and process for disciplining physician assistants should be spelled out in the bylaws. The process should involve PA peers and conform to the process applied to physicians.

Quality Assurance

The bylaws should provide for effective mechanisms to carry out quality assurance responsibilities with respect to physician assistants. Peer review of PA practice should be conducted by peers – ideally other physician assistants in the same area of clinical specialty. If the staff does not include other PAs in the same or similar specialty, PA peers from outside the hospital should be called in.

Continuing Education

The medical staff bylaws should require participation by physician assistants in continuing medical education that relates, at least in part, to their regular practice and to their clinical privileges.

Committees

Bylaws should allow physician assistant representation on medical staff committees, including the medical executive committee

Discrimination

The fundamental criteria for medical staff membership or clinical privileges should be directly related to the delivery of quality medical care, professional ability and judgment, and community need. Medical staff membership or particular clinical privileges should not be denied on the basis of gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, disability, socioeconomic status, or sexual orientation.

Participation in Disaster and Emergency Care

The bylaws should include language enabling physician assistants to provide care during emergency or disaster situations. The bylaws should state that the chief executive or his or her designee may grant temporary clinical privileges when appropriate and that emergency privileges may be granted when the hospital's emergency management plan has been activated. The hospital's emergency preparedness plan should include physician

assistants in its identification of care providers authorized to respond in emergency or disaster situations.

Bylaws language might state:

In case of an emergency, any member of the medical staff, house staff, and any licensed health practitioner, limited only by the qualifications of their license and regardless of service or staff status, shall be permitted to render emergency care. They will be expected to do everything possible to save the life of a patient, utilizing all resources of the hospital as necessary, including the calling of any consultations necessary or desirable. Any physician assistant acting in an emergency or disaster situation shall be exempt from the hospital's usual requirements of physician supervision to the extent allowed by state law in disaster or emergency situations. Any physician who supervises a physician assistant providing medical care in response to such an emergency or declared disaster does not have to meet the requirements set forth in these bylaws for a supervising physician.

Conclusion

- Physician assistants must seek delineation of their clinical privileges; the process must be outlined in medical staff bylaws.
- The AAPA believes that physician assistants should be members of the medical staff.
- Medical staff bylaws should require that each physician assistant be granted clinical privileges regardless of whether the PA is an employee of a practice or of the hospital.
- The criteria for delineating PA clinical privileges should be specified in the bylaws.
- AAPA opposes specialty certification examinations as a requirement for physician assistant credentialing or privileging.
- Duration of appointments and privileges should be the same for physicians and physician assistants.
- Bylaws should give physician assistants the right to due process when actions taken by the medical staff or governing board adversely affect his or her clinical privileges.
- The criteria and process for disciplining physician assistants should be spelled out in the bylaws. The process should involve PA peers and conform to the process applied to physicians

- Bylaws should provide mechanisms to carry out quality assurance with respect to PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the same area of clinical specialty.
- Bylaws should require PA participation in continuing medical education that relates to their practice and their privileges.
- Bylaws should allow PA representation on medical staff committees, including the medical executive committee.
- Bylaws should include language enabling physician assistants to provide care during emergency or disaster situations.

Endnotes

[1] Several states have no explicit educational requirement. However, because those states require national certification and because only graduates of accredited programs are eligible for the national certification exam, the certification requirements in the laws of those states are the functional equivalent of an educational requirement.

[2] Upon graduation from a physician assistant program, PAs must pass the NCCPA's initial certifying exam, the Physician Assistant National Certifying Examination (PANCE). To maintain current certification, PAs must complete 100 hours of continuing medical education every two years and pass the Physician Assistant National Recertification Examination (PANRE) every six years.

[3] CMS -3244-P, October 24, 2011 **Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation** (proposed rule) states: *"Alternatively, a hospital could establish categories within its medical staff to create distinctions between practitioners who have full membership, and a new category for those who could be classified as having an 'associate', 'special' or 'limited' membership. Such a structure is neither required nor suggested; we are providing it here as a possible way to align all of its practitioners under the 'Medical Staff' rules*." https://www.cms.gov/CFCsAndCoPs/Downloads/CMS3244P.pdf

[4] Standard 42CFR482.22(a) Code of Federal Regulations. Title 42-Public Health, Chapter IV-Centers for Medicare and Medicaid Services, Department of Health and Human Services. (10-1-10 Edition) Retrieved December 9, 2011. http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol5/pdf/CFR-2010-title42-vol5-sec482-22.pdf

[5] Centers for Medicare and Medicaid Services. State Operations Manual, Appendix A-Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, *(Rev. 75, 12-02-11)* Standard 482.22(a). **Tag A-0339**. Retrieved December 9, 2011 http://www.cms.gov/manuals/downloads/som107ap_a_hospitals.pdf

[6] AAPA 2011-2012 Policy Manual, HP-3100.1.3 and HP 3100.1.3.1, adopted 2008. http://www.aapa.org/uploadedFiles/content/About_AAPA/PM-11-12-Final.pdf

2012-B-07 – Rejected

AAPA endorses a ten year Maintenance of Certification (MOC- Recertification) 'Pilot Program' to start in 2013. The HOD charges the speaker to communicate this to the NCCPA (National Commission for Certification of PAs) BOD including all PAs.

2012-C-01 – Adopted

AAPA endorses the prescribing and distribution of naloxone for secondary administration to opiate addicted patients to prevent opiate overdose and supports the establishment of naloxone prescribing programs.

AAPA also advocates for legislative and regulatory changes as needed to remove legal and regulatory barriers to prescribing and dispending for secondary administration.

State constituent chapters are encouraged to collaborate with public health agencies, addiction treatment organizations, local and state medical societies and other entities to seek legislative and/or regulatory changes.

2012-C-02 – Adopted on Consent Agenda

AAPA is opposed to the use of tanning beds by adolescents and young adults under 18 years of age.

AAPA encourages state chapters to pursue and support legislation to restrict the use of tanning beds by individuals under 18 years of age.

Physician assistants should educate patients of all ages about the dangers of tanning and the importance of full skin exams yearly.

2012-C-05 – Rejected

The House of Delegates recommends to the AAPA Board of Directors the formation of a task force to discuss the appropriate title for the profession as well as the ramifications of a title change. The composition of the task force should include an objective and balanced blend of AAPA fellow members. The recommendations of the task force will be reported to the House of Delegates at their annual meeting in 2013.

2012-C-06 – Adopted on Consent Agenda

AAPA believes that information technology software should enable Physician Assistants to write appropriate, legal electronic prescriptions that comply with all state and federal guidelines. Therefore, AAPA encourages all electronic prescription software companies to incorporate the required parameters to facilitate efficient electronic prescribing by physician assistants and to ensure that physician assistants remain in compliance with both state and federal laws and rules.

2012-C-07 – Adopted as Amended

Amend policy HP-3300.1.17 as follows:

AAPA believes that all physician assistants should become knowledgeable of programs ~~sponsored by local governments, the private sector, and pharmaceutical companies~~ that make available prescription medications free of charge or at a reduced cost for ~~underinsured, uninsured, and underserved~~ patients.

2012-C-08 – Adopted on Consent Agenda

Amend the position paper entitled "Routine Vaccination for Human Papilloma Virus" as follows:

Routine Vaccination for Human ~~Papilloma Virus~~ PAPILLOMAVIRUS

EXECUTIVE SUMMARY OF POLICY CONTAINED IN THIS PAPER

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

- AAPA SUPPORTS ADDING HPV TO THE ROUTINE SCHEDULE OF VACCINATIONS AS RECOMMENDED BY ACIP.
- AAPA SUPPORTS COVERAGE OF HPV VACCINATION BY INSURERS AND PUBLIC FUNDING FOR HPV VACCINATION FOR UNINSURED PATIENTS.
- AAPA ENCOURAGES ALL PHYSICIAN ASSISTANTS TO DISCUSS AND RECOMMEND HPV VACCINATION FOR THEIR PATIENTS IN THE RECOMMENDED POPULATIONS.
- PHYSICIAN ASSISTANTS SHOULD CONTINUE TO DISCUSS THE IMPORTANCE OF SAFER SEX WITH ALL THEIR PATIENTS AND CONTINUE TO ADVISE ROUTINE SCREENING FOR HPV ASSOCIATED CANCERS IN ACCORDANCE WITH ACCEPTED GUIDELINES.

HUMAN PAPILLOMAVIRUS (HPV) IS THE MOST COMMON SEXUALLY TRANSMITTED INFECTION IN THE UNITED STATES (U.S.) WITH A SEROPREVELANCE OF 32.5% AND 12.2% OF HPV TYPE 6, 11, 16, AND 18 IN WOMEN AND MEN RESPECTIVELY. IT IS ESTIMATED THAT OVER 50% OF

ALL SEXUALLY ACTIVE INDIVIDUALS WILL BECOME INFECTED WITH HPV AT SOME POINT IN THEIR LIVES. HPV INFECTION CONTRIBUTES TO OROPHARYNGEAL AND ANOGENITAL CANCERS AND PRECANCERS, AND CONDYLOMA ACUMINATA. HPV RELATED ILLNESS RESULTS IN SIGNIFICANT COST TO THE HEALTHCARE SYSTEM. 1.6 BILLION DOLLARS ARE SPENT ANNUALLY ON HPV RELATED ILLNESS IN THE U.S.

AN ESTIMATED 22,000 HPV RELATED CANCERS OCCUR ANNUALLY IN THE UNITED STATES, INCLUDING AN ESTIMATED 7,000 HPV RELATED CANCERS IN MALES. ~~Cervical cancer is the second leading cause of cancer death in women around the world. In the US t~~There are over 11,000 cases of cervical cancer annually IN THE US. Oncogenic ~~human papilloma virus (~~HPV~~)~~ is found in 99.7% of all cervical cancers and ~~HPV is the most common sexually transmitted infection (STI) in the US.~~ eleven women die every day in the US from cervical cancer. Over 6,000 women in the US each year are diagnosed with HPV related anogenital cancers. ~~HPV is being increasingly recognized as a cause of oropharyngeal and penile cancers. HPV related illness results in significant cost to the healthcare system and a significant degree of emotional distress to an untold numbers of patients and their partners. Annually, 1.6 billion dollars are spent in the US on HPV related disease. It is now estimated that over 50% of all sexually active individuals will become infected with HPV at some point in their lives.~~

~~As healthcare providers, p~~Physician assistants must provide ~~the best possible~~ evidence based, QUALITY care for ~~our~~ ALL patients. Vaccines against HPV have the potential to significantly reduce morbidity and mortality ~~from this disease. Both the vaccine approved in June 2006 and the vaccine under review by the FDA in early 2008 report excellent efficacy and safety data.~~ THE FDA HAS LICENSED TWO HPV VACCINES. HPV4 (GARDASIL) PROTECTS AGAINST HPV TYPE 6, 11, 16 AND 18, AND HPV2 (CERVARIX) PROVIDES IMMUNITY AGAINST HPV TYPE 16 AND 18. BOTH VACCINES ARE RECOMMENDED FOR THE PREVENTION OF CERVICAL CANCERS AND PRECANCERS. HPV4 IS ADDITIONALLY RECOMMENDED FOR PREVENTION OF ANAL CANCERS AND PRECANCERS AS WELL AS CONDYLOMA ACUMINATA. Current studies ~~have shown~~

DEMONSTRATE ~~virtually 100% effectiveness~~ EFFICACY OF UP TO 99% when given to virus naïve individuals in the target age group.

The Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practice (ACIP) ~~has~~ recommendS~~ed that all~~ girls ages 11-12 ~~be vaccinated~~ UNDERGO ROUTINE VACCINATION and ~~that~~ catch up vaccination~~s~~ be offered for women up to age 26. THE ACIP RECOMMENDS ROUTINE VACCINATION WITH HPV4 (GARDASIL) FOR BOYS AGES 11-12 AND CATCH-UP VACCINATIONS IN MEN UP TO AGE 21 WITH PERMISSIVE VACCINATION UP TO AGE 26. ROUTINE VACCINATION IN BOYS AND MEN WILL HELP DECREASE THE DIRECT BURDEN OF HPV-ASSOCIATED DISEASE IN MEN AS WELL AS INDIRECTLY BENEFIT FEMALES THROUGH HERD IMMUNITY.

FOR IMMUNOCOMPROMOMISED MALES AND MEN WHO HAVE SEX WITH MEN (MSM), THE ACIP RECOMMENDS ROUTINE VACCINATION WITH HPV4 AS FOR ALL MALES, AND VACCINATION THROUGH AGE 26 YEARS FOR THOSE WHO HAVE NOT BEEN VACCINATED PREVIOUSLY OR WHO HAVE NOT COMPLETED THE 3-DOSE SERIES. MSM ARE AT HIGHER RISK FOR INFECTION WITH HPV AND FOR HPV ASSOCIATED CONDITIONS, INCLUDING GENITAL WARTS AND ANAL CANCERS AND PRECANCERS.

Vaccination is most effective prior to the onset of any type of sexual activity and the immune response is optimal in the target age group. Some parents and ~~perhaps a few~~ clinicians are uncomfortable broaching the subject of sexuality with patients in the target age group and as a result may be reluctant to discuss the need for vaccination. ~~The facts about the benefits of vaccination are sometimes lost in the emotional and often political debates that erupt whenever issues relate to sexual activity.~~ Physician assistants can play a key role in initiating AN objective, PATIENT-CENTERED discussion on the benefits of vaccination against HPV.

CONCLUSION

~~Therefore the~~ AAPA supports adding ~~the~~ HPV ~~vaccine~~ to the routine schedule of vaccinations as recommended by ACIP. In addition ~~the~~ AAPA supports coverage of ~~the~~ HPV vaccin~~e~~ATION by insurers and public funding for ~~the~~ HPV vaccin~~e~~ATION for UNINSURED patients ~~without insurance~~. Furthermore ~~the~~ AAPA encourages all physician assistants to discuss and recommend HPV vaccination for their patients in the

recommended populationS. Physician assistants should continue to discuss the importance of safer sex with all their patients and continue to advise routine screening for ~~cervical~~ HPV ASSOCIATED cancerS in accordance with accepted guidelines.

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2012-C-09 – Adopted on Consent Agenda

AAPA supports laws, policies, regulations, and judicial precedents regarding people living with HIV/AIDS that are in accordance with the following principles:

(1) should not place unique or additional burdens on such individuals solely as a result of their HIV status; and
(2) should instead demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—
    (A) the multiple factors that lead to HIV transmission;
    (B) the relative risk of HIV transmission routes;
    (C) the current health implications of living with HIV;
    (D) the associated benefits of treatment and support services for people living with HIV; and
    (E) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and

communities.

2012-C-10 – Adopted as Amended

AAPA encourages ~~efforts to elect~~ physician assistants to ~~**RUN FOR**~~ **SEEK ELECTION TO** Federal, ~~and~~ state, AND LOCAL legislative bodies.

2012-C-11 – Adopted on Consent Agenda

Amended policy HX-4600.2.3 as follows:

The AAPA supports the ~~continuation of~~ current law which allows rural health clinics to maintain certification regardless of the shortage area designation status until such time as a process has been developed that ensures CONTINUATION OF access to appropriate care for the patients served by the clinics.

2012-C-12 – Adopted on Consent Agenda

Amend policy HX-4100.1.2 as follows:

The American Academy of Physician Assistants encourages all of the nations' ~~jails~~ CORRECTIONAL FACILITIES to seek accreditation through on-site evaluation using the National Commission on Correction Health Care's (NCCHC) *Standards for Health Services in Jails* AND *STANDARDS FOR HEALTH SERVICES IN PRISONS*.

~~The American Academy of Physician Assistants encourages all state and federal prisons to seek accreditation through on-site evaluation using NCCHC's Standards for Health Services in Prisons.~~

The American Academy of Physician Assistants encourages all juvenile confinement facilities to seek accreditation using NCCHC's Standards for Health Services in Juvenile Confinement Facilities.

The American Academy of Physician Assistants encourages all correctional health professionals to maintain their professional credentials and seek recognition through NCCHC's Certified Correctional Health Professional Program.

2012-C-13 – Adopted on Consent Agenda

Adopt the position paper entitled Proliferation and Dispersal of Anti-personnel Weapons.

Proliferation and Dispersal of Anti-personnel Weapons

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.

- The AAPA believes in supporting national and international efforts to reach a permanent ban on the use and proliferation of landmines.
- The AAPA advocates for expanded support by the United States for programs to clear landmines.
- The AAPA advocates for continued support by the United States for to provide long-term assistance to victims of land mines.
- Physician assistants should understand the risk for injury and death (particularly among children) from other types of unexploded ordnance.
- AAPA supports programs currently aimed at clearance of landmines, and assistance to victims, and recognizes the contribution that our country has made to clear landmines and assist victims. The dangers from unexploded ordnance should not be overlooked as they pose a risk to health care workers and others providing care . Advocacy for a permanent international ban on other unexploded ordnance is necessary.

Introduction

Persistence of armed unexploded ordnance (UXO) such as landmines present a significant public health risk in many countries. [1] This is particularly tragic, since the healthcare infrastructure in post-war countries is typically ill equipped to manage acute devastating trauma or support amputees. In addition, the consequences of landmines extend beyond the borders of those countries. Health-care workers and nongovernmental organizations employees are at increased risk of injuries as they themselves provide assistance in areas of conflict.

Injuries Associated with Landmines and Unexploded Ordnance

In 2003, the Centers for Disease Control and Prevention (CDC) estimated that there were 60-70 million landmines scattered throughout the world. As many as 70 countries have retained munitions, and it estimated that 24,000 persons, mostly civilians, are killed or injured annually by landmines and other unexploded ordnance (UXO).[1,2] Beside land mines, several other types of anti-personnel munitions can persist in an armed but undetonated state. These include grenades, mortor and artillary shells, expended rockets, and cluster munitions. Cluster munitions are compound bombs that contain hundreds of bomblets which are designed to remain active beyond the initial explosion, disperse and detonate secondarily. It is not uncommon for bomblets to remain undetonated and dangerous for years.

Data from limited published studies indicate that children account for approximately one half of injuries and deaths from all types of UXO. Adult males suffer the majority of civilian casualties from landmines, often when traveling or farming. Children under 18 years of age are more than two times more likely to be injured by other types of UXO, while playing or tending animals.[1,2] Those who survive the initial trauma are left with disfiguring and disabling injuries, including blindness and amputations. The social, medical and rehabilitative infrastructure is not capable of assisting these individuals.

To its credit, the U.S. is the world's biggest provider of financial and technical assistance to mine clearance programs and other programs that destroy conventional weapons around the world.[3,4,5] U.S. Humanitarian Mine Action Program (a federal interagency partnership) has invested more than $1.5 billion in mine clearance action in nearly 50 countries over the last three decades.[6] In 2009, the United States Department of State declared the western hemisphere, from the Arctic to the border of Columbia was free from unexploded ordnance, including landmines.[6]

The United States last used antipersonnel mines in 1991 (in Operation Desert Storm), has not exported them since 1992, and has not produced landmines since 1997.[3] However, it still retains 10.4 millions of stockpiled antipersonnel mines for potential future use.[3]

It remains one of only 38 countries (including Cuba, Russia, and China) in the world that have not joined the Mine Ban Treaty (the Ottowa protocol), in force since 1999.[7] In addition, in 2008, the U.S. refused to join 80 counties in signing a 2008 treaty to ban cluster munitions and it continues to oppose such a ban, claiming these weapons are legitimate tactical defensive weapons.[8]

The impact of politics should not be understated. It is plausible that a divergence of opinions among federal departments exists, over the issue of security versus humanitarianism. In late 2009, the Obama administration undertook an extensive review of America's policy related to use of landmines and other anti-personnel weapons, after initially reporting that it would maintain the policy established by the prior administration. In 2011, without yet concluding its review, the U. S. attended the eleventh meeting of states parties to the land mine treaty as an observer.[9]

Conclusion

AAPA supports all efforts leading to a permanent ban on the production, stockpiling, trade and use of indiscriminate antipersonnel weapons such as landmines and cluster

munitions; and supports the United States government's significant ongoing involvement in safely removing these weapons and in assisting victims of antipersonnel weapons.

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2012-C-14 – Adopted on Consent Agenda

Amend policy HX-4200.1.1 as follows:

AAPA endorses the use of the U.S. Department of Health and Human Services' report Healthy People and its subsequent initiatives which serve as a guide to improve the health of the nation.

All physician assistants should become familiar with the goals and objectives of Healthy People initiatives to improve ~~the~~ health PROMOTION, HEALTH EQUITY, AND DISEASE PREVENTION IN THEIR COMMUNITIES. ~~of patients and communities and apply them to their practice.~~

2012-C-15 – Adopted on Consent Agenda

Amend policy HX-4600.1.4 as follows:

AAPA recognizes THE UNIQUE NEEDS OF UNDERSERVED POPULATIONS, and encourages ~~medical practitioners~~ PHYSICIAN ASSISTANTS to provide care to ALL ~~needy~~ patients.

AAPA supports the development of programs and elimination of barriers to care for ~~underinsured and uninsured patients.~~ ALL PATIENTS. Incentives offered by government or private entities promoting ~~such~~ MORE EQUITABLE AND ACCESSIBLE care should be available to all health care practitioners.

New Business

2012-E-01 - Adopted by Acclamation

Granting Marilyn Fitzgerald the Title "Honorary Physician Assistant"

Whereas, the kindness and compassion of Marilyn Fitzgerald continues to make a difference in the lives of those she encounters, and

Whereas, Marilyn Fitzgerald has long been a calm guiding hand for the Physician Assistant Profession, and

Whereas, Marilyn Fitzgerald served as a member of the American Academy of Physician Assistant staff for almost thirty-five years, and

Whereas, she has helped shaped the Academy including the Student Academy, the House of Delegates, and the Board of Directors, and

Whereas, she has been an important part of the growth of the profession from a few thousand PAs in 1977 to over 85 thousand today, and

Whereas, she has taken an active role in mentoring and transitioning PAs and PA leaders during their careers from student to fellow, and

Whereas, the majority of Physician Assistants have not known an Academy without the wise guidance of Marilyn Fitzgerald, and

Whereas, almost all of the current Physician Assistant students were not yet born when Marilyn joined the AAPA, and unfortunately will not know her kindness, mentorship and dedication to the profession, and

Whereas, the Physician Assistant profession cannot imagine a PA world without the presence of Marilyn Fitzgerald;

Resolved, that the AAPA House of Delegates, on behalf of a grateful Physician Assistant profession, bestows upon Marilyn Fitzgerald the title "Honorary Physician Assistant."

Resolutions of Condolence or Commendation

2012-COND-01

Resolution of Condolence for Ron Nelson

In Honorarium

Whereas, Ron L. Nelson passed away on June 11, 2011 at the age of 58; and

Whereas, Ron L. Nelson was a pioneer and driving force for the physician assistant profession; and

Whereas, Ron L. Nelson worked diligently and was integral in assisting his fellow physician assistants in the implementation of model practice legislation in the state of Michigan when the profession was still in its infancy; and

Whereas, Ron L. Nelson advocated for the first two Michigan physician assistant programs at Western Michigan University and Mercy College of Detroit; and

Whereas, Ron L. Nelson served as Michigan Academy of Physician Assistants President in 1983-1984 and served in many capacities in assisting the Michigan Academy of Physician Assistants in its early years and beyond; and

Whereas, Ron L. Nelson was a gubernatorial to the Michigan Board of Osteopathic Medicine and was twice honored as Michigan's Outstanding PA of the Year; and

Whereas, Ron L. Nelson served two distinguished terms as President of the American Academy of Physician Assistants; and

Whereas, Ron L. Nelson was second to none in his advocacy for the Rural Health Clinics of Michigan, started the Michigan Association of Rural Health Clinics and served as its Executive Director, assisted in establishing many Michigan Rural Health Clinics and developed Michigan's first Mobile Rural Health Clinic and was co-founder of the National Association of Rural Health Clinics; and

Whereas, Ron L. Nelson made health care more accessible in small towns and medically underserved areas across the nation by serving as a consultant to many of us on how to establish and operate rural health clinics or community health centers. The results of his efforts live on in the continued availability of health care in communities throughout the country.

Whereas, Ron L. Nelson could always be counted on in an emergency. Ron led the successful nationwide grassroots campaign that saved the Rural Health Clinic program from being eliminated by Congress in 1996. This program now includes 3500 clinics providing medical care to the underserved patients across rural America.

Whereas, Ron L. Nelson received the Michigan Rural Health Association Annual Award in 1997; and

Whereas, Ron L. Nelson has lectured to and mentored thousands of Michigan physician assistant students and participated as Faculty for Western Michigan University, Grand Valley State University and Central Michigan University 's Physician Assistant Programs; and

Whereas, Ron L. Nelson gave countless presentations on Reimbursement to the Practicing Physician Assistants of Michigan and nationally; and

Whereas, Ron L. Nelson's expertise in the intricacies of reimbursement for medical services assisted small clinics, hospitals and large medical practices across the country in effectively utilizing PA services.

Whereas, Ron L. Nelson was the recipient of the Michigan Academy of Physician Assistants President's Award in 1983 and was an Honorary Lifetime Member of the Michigan Academy of Physician Assistants; and

Whereas, Ron L. Nelson served on the Board of Directors for Molina Health Care of Michigan; and

Whereas, Ron L. Nelson passionately committed to preserving and improving the health of the patients he served. He always had time for people and did not turn anyone away. He was particularly loved by his Amish patients, who especially appreciated his house calls; and

Whereas, Ron L. Nelson was singularly instrumental in mentoring countless fellow physician assistants to advocate and lead the profession he so dearly loved.

Whereas, Ron L. Nelson lives on in our memories as an inspiration on how to leave this world a better place.

Therefore, be it resolved by the AAPA House of Delegates

1. That the American Academy of Physician Assistants posthumously honors Ron L. Nelson for his personal accomplishments and service to the Physician Assistant profession.
2. That the American Academy of Physician Assistants extends its sympathy and condolences to the family of Ron L. Nelson.
3. And, that a copy of this resolution is sent to the family of Ron L. Nelson, PA-C.

2012-COMM-01

Resolution of Commendation for Michael R. Milner

Motion for Commendation for RADM (ret) Michael R. Milner for 33 years of federal service and 30 years of AAPA support and affiliation.

Whereas, Michael R. Milner was a pioneer for Physician Assistants in the Uniformed Services; and

Whereas, Michael R. Milner served in the United States Air Force as a Medic from 1973 to 1982 before entering the Physician Assistant program at the University of Oklahoma College of Medicine; and

Whereas, Michael R. Milner received his commission in the United States Air Force Biomedical Science Corps assigned to the 832nd Medical Group Hospital at Luke Air Force Base; and

Whereas, Michael R. Milner served as the Chief Physician Assistant in the United States Public Health Service for the Director of Indian Health Services and worked to improve the health of Native Americans and Alaska Natives; and

Whereas, Michael R. Milner served as Clinical Coordinator for the Clinical Diabetes Research Unit of the Phoenix Indian Medical Center as part of a National Institutes of Health-sponsored investigation of the causes of Diabetes Mellitus in Pima Indians; and

Whereas, Michael R. Milner was selected as Chief Professional Officer for the Health Services category which represents 850 Commissioned Corps Officers in more than 50 health professional disciplines; and

Whereas, Michael R. Milner as a United States Public Health Commissioned Corps Officer became the first General Officer in all Uniformed Services; and

Whereas, Michael R. Milner served as Regional Health Administrator (RHA) for Region I (Boston) where he was responsible for the six New England states as the principle Federal Public Health Official and senior US Public Health Service Commissioned Corps Officer; and

Whereas, Michael R. Milner served the AAPA and its members as a member of the Federal Services Task Force, JCAHO appointee for Medical Staff Chapter revisions, member of the Hospital Privileges Committee, member of Reference Committee B of the HOD and a member of the PA Foundation Scholarship Committee;

Therefore be it resolved, that the House of Delegates of the American Academy of Physician Assistants recognize Michael R. Milner's many contributions to his country, the AAPA, United States Public Health Service, United States Air Force, and the Physician Assistant profession as a whole;

And be it further resolved, that a copy of this commendation is presented to Michael R. Milner with the deepest gratitude of the members of the American Academy of Physician Assistants.

2012-COMM-02

Resolution of Commendation for Scott Frischknecht

Whereas, Scott Frischknecht is as skilled at twisting arms as he is in orthopedic medical care, and

Whereas, Scott Frischknecht has so skillfully twisted our arms for so many years on behalf of the AAPA Political Action Committee (PAC), and

Whereas, This is the last year that Scott will be fundraising before the AAPA HOD as Chairman of the AAPA PAC Board of Trustees, and

Whereas, Scott leaves us with full hearts and empty wallets;

Therefore be it resolved, that the AAPA House of Delegates thanks and commends Scott Frischknecht for his many years of exceptional service on behalf of the AAPA PAC and AAPA'S advocacy efforts.

2012-COMM-03

Resolution of Commendation for Bruce Fichandler

Whereas, Mr. Bruce Fichandler, of Connecticut, has served the American Academy of Physician Assistants for over 30 years, and

Whereas, Mr. Fichandler has been a loyal member of AAPA for over 30 years and has served for most of that time as a leader of the organization, and

Whereas, Mr. Fichandler has served the AAPA as President (1990-1991) and as President-Elect and Immediate Past President in the preceding and following years, and

Whereas, Mr. Fichandler has served the AAPA House of Delegates as its Speaker (1984-1988), concurrently serving on the AAPA Board as Vice President, and

Whereas, Mr. Fichandler has served the AAPA as its Treasurer on two different occasions (1980-1984; 1992-2012), and

Whereas, Mr. Fichandler began his service to the AAPA as a member of the Publications Committee (1978-1980), and

Whereas, Mr. Fichandler founded the AAPA's President's Philanthropic Project (known later as the Host City Prevention Campaign and now called Caring for Communities), and

Whereas, Mr. Fichandler encouraged the AAPA's involvement in literacy education; and

Whereas, Mr. Fichandler is a past recipient of the House Outstanding Service Award, and

Whereas, Mr. Fichandler is a member of the Physician Assistant Foundation's Legacy Circle, and

Whereas, Mr. Fichandler has served the Connecticut Academy of Physician Assistants for over 30 years; and

Whereas, Mr. Fichandler has served ConnAPA in various roles, including: Treasurer, President and Web-Master;

Therefore be it resolved, that the House of Delegates offers its heartfelt thanks to Bruce's family for the time they have sacrificed with him as he did work on behalf of the PA profession, and be it further

Resolved, that this House of Delegates thanks him for his service in this House, and be it further

Resolved, that Mr. Bruce Fichandler receive the thanks and commendation of this 2012 House of Delegates in recognition of his dedication and service to the AAPA and ConnAPA.

2012-COMM-04

Resolution of Commendation for Joyce Ann Clayton Nichols

Joyce attended North Carolina College at Durham (now North Carolina Central University), Durham Technical College, the University of North Carolina at Chapel Hill and Duke University Physician Assistant Program.

She served as a licensed practical nurse for 5 years in Cardiology.

Broke Ceilings

Joyce was the first formally educated female physician assistant accepted into the Duke program on her third application. At the time, the program was 100% male (students and faculty), and she was the first African American female physician assistant to graduate in 1970.

Perseverance

During her first year as a PA student, her house was destroyed by fire, losing everything. The students and faculty raised funds to assist her and her family and keep her in the program.

First Job

Joyce worked for Dr Charles Johnson, first African American physician to join the Duke University faculty because there was concern about how patients would accept her as a provider.

Pioneer

Along with Dr Harvey Estes, Joyce created the first rural clinic in the United States in North Carolina and worked there until is was taken over by the Lincoln Health Center Clinic and worked there for 23 years retiring in 1995.

Advocacy Triumphs

Joyce spent many years providing service to poor and homeless families in Durham, North Carolina, served as a Commissioner to the Durham Housing Authority for 15 years, took a case to the US Supreme Court to prevent low income residents of public housing evictions due to lack of rent payments.

Joyce was a member of the Durham County Hospital Corporation and Lincoln Center Board of Directors.

Professional Service

Joyce is a charter member to the AAPA Board, NCAPA Board, MAC Committee, assisting with creation of bylaws.

Educator

Joyce was an adjunct faculty to the Duke University Physician Assistant Program. She was also a preceptor and mentor to many.

Recognition

Joyce was awarded the Nancy Susan Reynolds Award for Advocacy in 1991, the AAPA Humanitarian Award in 1996 and was inducted into the Duke University Physician Assistant Alumni Hall of Fame in 2002. She was the recipient of the Long Leaf Pine Award from the Governor of North Carolina, the highest award given to citizens for their public service in 2008.

This role model for the profession needs to hear our prayers as her physical health declines, her spirit, inspiration, tenacity and leadership humbles us to remember where we came from as we proceed with serving our patients.

2012-COMM-05

Resolution of Commendation for Marilyn Fitzgerald

Whereas, Marilyn Fitzgerald was a loyal member of the American Academy of Physician Assistants staff from July 18, 1977 until her retirement March 16, 2012,

Whereas, Marilyn Fitzgerald was devoted to the American Academy of Physician Assistants and spent many of her nights, weekends, and holidays in her service to the Academy and to physician assistants,

Whereas, she was instrumental to the formation of past and current governance structures of the AAPA including the formation of the House of Delegates,

Whereas, she has been a mentor, friend, and confidant of AAPA members and leaders for more than 30 years,

Whereas, Marilyn Fitzgerald is the institutional memory of the American Academy of Physician Assistants,

Whereas, her leadership and guidance was essential to creating the effective and collegial House of Delegates that we enjoy today,

And whereas, through her work in the Academy and the House of Delegates, she has enhanced the lives of generations of physician assistants and their patients,

Resolved, the House of Delegates of the American Academy of Physician Assistants thanks Marilyn Fitzgerald for the mentorship, friendship, and assistance she has provided numerous AAPA leaders and innumerable AAPA members,

And Further Resolved, the House of Delegates appreciates the many nights, weekends, and Memorial Days that she spent with us instead of her friends and family,

And Further Resolved, that the House of Delegates of the American Academy of Physician Assistants recognizes Marilyn Fitzgerald for her years of toil, and many contributions to the American Academy of Physician Assistant, the AAPA House of Delegates, physician assistants and their patients,

And Further Resolved, that a copy of this resolution be provided to Marilyn Fitzgerald as lasting memory of the thanks of the AAPA House of Delegates and the Physician Assistant Profession.

House Elections 2012	**Results**
Vice President/Speaker	Alan Hull
First Vice Speaker	L. Gail Curtis
Second Vice Speaker	David Jackson
Nominating Work Group	Andrew Booth
	James Ginter

(Positions for House Officer and Nominating Work Group were voted upon unanimously as there were no contested positions.)