Current AAPA Policies[1] Related to the Issue of PA Practice Authority/Responsibility/Scope
As of July 2016

HP-3100.2.1
PAs practice medicine in teams with physicians and other health care professionals. *[Adopted 1980, reaffirmed 1990, 1993, 2000, 2005, 2010, amended 1991, 1996, 2015]*

HP-3100.3.1
PAs are health professionals licensed or, in the case of those employed by the federal government, credentialed to practice medicine in collaboration with physicians. PAs are qualified by graduation from an accredited PA educational program and/or certification by the National Commission on Certification of Physician Assistants.

Within the physician-PA relationship, PAs provide patient-centered medical care services as a member of a health care team. PAs practice with defined levels of autonomy and exercise independent medical decision making within their scope of practice. *[Adopted 1995, reaffirmed 2000, 2005, 2010, amended 1996, 2014]*

HP-3300.1.1
PAs, by virtue of their education and legal scope of practice as professionals who provide medical care in teams with physicians, are qualified to order and monitor the use of patient restraint and seclusion. This applies to restraints when used in conjunction with a medical or surgical procedure and when used for behavioral reasons. Restraint or seclusion should only be for the purpose of protecting the patient or others or to improve a patient's functional well-being, and only if less intrusive interventions have been determined to be ineffective. *[Adopted 2000, reaffirmed 2005, 2010, 2015]*

HP-3400.1.1
It is the obligation of each PA to ensure that:

- The individual PA's scope of practice is broadly identified;
- The scope is appropriate to the individual PA's level of training and experience;
- Access to the collaborating physician is defined;
- A process for collaboration is established.

AAPA is committed to the concept of team-based collaborative practice between the PA and physician to achieve the highest level of quality, cost effective care for patients and continued professional growth and lifelong learning. *[Adopted 1980, reaffirmed 1990, 1993, 2000, 2005, 2010, amended 1991, 1996, 2015]*

HP-3400.1.2
AAPA believes that the physician-PA team relationship is fundamental to the PA profession and enhances the delivery of high-quality health care. As the structure of the health care system changes, it is critical that this essential relationship be preserved and strengthened. *[Adopted 1997, reaffirmed 2002, 2007, 2012]*

HP-3400.1.3

[1] This review included the AAPA Policy Manual (including AAPA Bylaws, House Policy, Board Policy, and AAPA Policy and Position Papers), and the AAPA Board Manual.

AAPA supports expanded health care access for all people. AAPA encourages innovation in health care delivery, but remains committed to the model of physician directed team care. AAPA maintains that continuity of care is a high priority; therefore communication between the episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality and patient preference. *[Adopted 2003, reaffirmed 2008, 2013]*

HP-3400.2.1
AAPA supports measures that allow for flexible and efficient utilization of PAs consistent with the provision of quality health care. More specifically, PA employment and supervision are separate issues. The regulatory requirements of PA supervision should be unrelated to any aspect of employment. *[Adopted 1996, amended 1997, reaffirmed 2001, 2007, 2012]*

HP-3400.2.4
AAPA shall promote the PA profession to hospital administrators, health care leaders and PA employers as a cost-effective, team-based and patient-centered way to improve the quality, access and continuity of patient care. *[Adopted 2000, reaffirmed 2005, amended 2010, 2015]*

HP-3600.1.5
AAPA believes that services provided by physician-PA teams should be counted when federal and state governments determine the primary health care service needs of medically underserved and health professional shortage areas. Recognition of physician-PA team productivity should not be done in such a way as to decrease patient access to care. *[Adopted 1998, reaffirmed 2003, 2008, 2013]*

HP-3700.1.1
AAPA believes that PAs must acknowledge their individual responsibilities to patients, society, other health professionals, and to themselves; and in meeting their responsibilities, their actions should be guided by the Guidelines for Ethical Conduct for the PA Profession. AAPA believes the endorsement of the Guidelines for Ethical Conduct is a professional responsibility that underscores the principle of self-regulation. *[Adopted 1990, amended 1991, 2001, reaffirmed 1996, 2006, 2011, 2016]*

HP-3700.3.1
Guidelines for PAs Working Internationally

1. PAs should establish and maintain the appropriate physician-PA team.
2. PAs should accurately represent their skills, training, professional credentials, identity, or service both directly and indirectly.
3. PAs should provide only those services for which they are qualified via their education and/or experiences, and in accordance with all pertinent legal and regulatory processes.
4. PAs should respect the culture, values, beliefs, and expectations of the patients, local health care providers, and the local health care systems.
5. PAs should be aware of the role of the traditional healer and support a patient's decision to utilize such care.
6. PAs should take responsibility for being familiar with, and adhering to the customs, laws, and regulations of the country where they will be providing services.
7. When applicable, PAs should identify and train local personnel who can assume the role of providing care and continuing the education process.
8. PA students require the same supervision abroad as they do domestically.
9. PAs should provide the best standards of care and strive to maintain quality abroad.
10. Sustainable programs that integrate local providers and supplies should be the goal.

11. PAs should assign medical tasks to nonmedical volunteers only when they have the competency and supervision needed for the tasks for which they are assigned. *[Adopted 2001, amended 2011, reaffirmed 2006, 2016]*

HX-4100.1.8
AAPA endorses the 1975 World Medical Association Declaration of Tokyo which provides guidelines for physicians and, by nature of their dependent relationship, for PAs, in cases of torture or other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment. *[Adopted 1987, reaffirmed 1992, 1997, 2003, 2008, 2013]*

HX-4500.1
AAPA believes that telemedicine can improve access to cost-effective, quality health care and improve clinical outcomes by facilitating interaction and consultation among providers. Because of the potential of telemedicine to enhance the practice of medicine by physician-PA teams, AAPA encourages PAs to take an active role in the utilization and evaluation of this technology. AAPA supports further research and development in telemedicine, including resolution of problems related to regulation, reimbursement, liability, and confidentiality.
[Adopted 1997, reaffirmed 2002, 2007, 2012]

HX-4500.3
AAPA believes that electronic health record (EHR) systems, computerized provider order entry (CPOE) systems, reimbursement and claims systems, and other health information technology systems should individually recognize and support the optimal utilization of PAs, and, when appropriate, provide attribution to PAs.

Health information technology systems should be designed, developed, and implemented with appropriate PA input in a manner that benefits patients, the physician-PA team, and the health care system by improving quality, encouraging patient-centered care, and reducing costs. *[Adopted 2013]*

HX-4600.1.3
Coverage for the treatment of mental health and substance use disorders should be available, nondiscriminatory and covered at the same benefit level as other medical care. Reimbursement for PAs providing mental health and substance use disorder care should be provided in the same manner as other physician services provided by PAs. *[Adopted 2003, reaffirmed 2008, amended 2013]*

HX-4600.3.5
AAPA recognizes the shortage of health care services in the United States and its expected impact on the quality, availability, and cost of health care in this country. AAPA is committed to raising awareness of this issue nationally and to increasing the importance of this issue on the policy agenda at all levels of government and in the private sector. AAPA supports efforts that promote and foster creative solutions to health care shortages that include expansion and access to physician-PA teams to meet anticipated requirements for health care services. *[Adopted 2006, reaffirmed 2011, 2016]*

HX-4700.4.2
AAPA supports the medical home concept as a means to expand access, reduce long-term cost, and improve the quality of patient care and the health of populations by allowing improved patient care coordination and interdisciplinary communication.

A medical home provides coordinated and integrated care that is patient- and family-centered, culturally appropriate, committed to quality and safety, and is cost-effective. This care is provided by a team led by a health care professional that includes PAs.

The principles of the medical home can apply to any setting where continuing, longitudinal primary or specialty care is provided. By virtue of their education, credentials, and fundamental support for team care, PAs are qualified to serve as patients' personal providers in the patient-centered medical home. PAs are qualified to lead the medical home and are committed to physician-PA team practice.

AAPA believes that coordination of care has value that requires a reasonable level of payment.
[Adopted 2008, amended 2010, 2015]

Comprehensive Health Care Reform
(Adopted 2005, amended 2010, 2013)
AAPA supports health care that is delivered by qualified providers in physician-directed teams.

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

Highlights of Findings from Data Collection and Stakeholder Engagement

Systematic review for published/disseminated literature relevant to clinical postgraduate PA training produced a small yield, considering the length of time such programs have existed, and key findings include the following. The term limited study here acknowledges publications that have limited generalizability, such as being conducted at a single site, evaluating small sample sizes, or study designs that are not intended to demonstrate cause and effect.

- Limited study in critical care demonstrates clinical postgraduate PA (and APRN) training positively impacted patient care and enhanced the training of other healthcare professionals in critical and intensive care settings
- Limited study in emergency medicine demonstrated that the vast majority program faculty surveyed felt PA students had sufficient training from entry level PA education for emergency medicine practice and more than half did not see a need for clinical postgraduate PA training

Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs (Adopted 2012)

Definition of PA
The following definition [of a PA] serves as an example.

> *A PA is an individual who is a graduate of a PA 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.*

Credentialing PAs
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 PAs, these criteria might include:

- evidence of national certification
- letters from previous employers, supervising physicians, PA 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.

PA Privileges

The fundamental premise of the PA profession is a solid educational foundation in medicine and surgery that prepares PAs to work with physicians in any specialty or care setting.

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.

Participation in Disaster and Emergency Care

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

Bylaws language might state:

In case of an emergency, any member of the medical staff, house staff, and any licensed health practitioner, limited only by the qualifications of their license and regardless of service or staff status, shall be permitted to render emergency care. They will be expected to do everything possible to save the life of a patient, utilizing all resources of the hospital as necessary, including the calling of any consultations necessary or desirable. Any PA 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 PA 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.

Guidelines for State Regulation of PAs (Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011, 2013, 2016)

Definition of a PA

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

Licensure

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

Applicants who meet the qualifications for licensure should be issued a license. States should not require employment or identification of a collaborating physician(s) as a condition or component of licensure.

Collaboration

The definition of collaboration should convey a process in which PAs and physicians jointly contribute to the healthcare and medical treatment of patients with each collaborator performing actions he or she is licensed to otherwise perform. Collaboration shall be continuous but shall not be construed to require the physical presence of the physician at the time and place that services are rendered. It is imperative, however, that the PA and a collaborating physician have access to each other. Even when practicing in collaboration with a physician, PAs are responsible for the care they provide. Nothing in the law should require or imply that the collaborating physician is responsible or liable for the care provided by the PA unless the PA is acting on the specific instructions of a physician.

Collaborating physician should be defined as an allopathic or osteopathic physician (MD or DO) licensed to practice in the state, who agrees to collaborate with PA(s). For PAs who practice in federal jurisdictions, collaboration may be provided by a physician (MD or DO) who meets the licensing requirements of the federal agency. Licensure in the state should not be required for federal collaborating physicians if it is not required by the federal agency. In group practice situations or in the hospital or its emergency department, provisions should be made for all staff physicians who so choose to collaborate with PAs who practice in the group or institution.

The guiding principles of team practice must be that it (a) protects the public health and safety, and (b) preserves the PA's access to physician consultation when indicated. Consequently, it is recommended that the ratio of PAs to collaborating physicians be determined by physician(s) and PAs according to the nature of the services being provided and according to the tenets of good patient care. Language that specifies mandatory ratios of PAs to collaborating physicians should be avoided. In addition, there should be no limit on the number of collaborating physicians each PA may have.

Because the state licenses both physicians and PAs and can discipline or revoke or restrict the license of both types of providers, it is redundant and unnecessary for the law to require physicians or PAs to file notice of collaborative arrangements with an agency.

Notwithstanding the above provisions, these guidelines recognize that medicine is rapidly changing. A modified model may be better for some states and they should therefore feel free to craft alternative provisions. PAs practice team based medicine with a wide variety of team members to include physicians. Language in state law should acknowledge consultation and/or collaboration between physicians and PAs in a manner that assures quality medical care and promotes access.

PA Practice Ownership and Employment

Employment and collaboration should be regarded as separate entities. A physician's ability to collaborate with a PA is independent of the specifics of PA employment. In the early days of the profession the PA was commonly the employee of the physician. In current systems physicians and PAs

may be employees of the same hospital or health system. In some situations the PA may be part or sole owner of a practice. PA practice owners may be the employers of their collaborating physicians.

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

Disasters, Emergency Field Response and Volunteering
PAs should be allowed to provide medical care in disaster and emergency situations. This may require the state to adopt language exempting PAs from collaboration provisions when they respond to medical emergencies that occur outside the place of employment. This exemption should extend to PAs who are licensed in other states or who are federal employees. Physicians who collaborate with PAs in such disaster or emergency situations should be exempt from routine documentation or collaborative requirements. PAs should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.

PAs who are volunteering without compensation or remuneration should be similarly exempted from collaboration provisions.

Scope of Practice
State law should permit PA practice in all specialties and settings. In general, PAs should be permitted to provide any legal medical service that is within the PA's skills, education, training and experience. Medical services provided by PAs may include but are not limited to ordering, performing and interpreting diagnostic studies, ordering and performing therapeutic procedures, formulating diagnoses, providing patient education on health promotion and disease prevention, providing treatment and prescribing medical orders for treatment. This includes the ordering, prescribing, dispensing, administration and procurement of drugs and medical devices. PA education includes extensive training in pharmacology and clinical pharmacotherapeutics. Additional training, education or testing should not be required as a prerequisite to PA prescriptive authority. PAs who are prescribers of controlled medications should register with the Federal Drug Enforcement Administration.

Dispensing is also appropriate for PAs. The purpose of dispensing is not to replace pharmacy services, but rather to increase patient ability to receive needed medication when access to pharmacy services is limited. Pharmaceutical samples should be available to PAs just as they are to physicians for the management of clinical problems.

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

PAs as Medical Review Officers (Adopted 1991, amended 2004, reaffirmed 2009, 2014)

AAPA believes that the medical knowledge and training necessary to ensure competence as an MRO are not limited to licensed physicians. As practitioners trained in the medical model to provide physician services, PAs have the background necessary to perform successfully the duties of an MRO.

PA Impairment (Adopted 1990, amended 1992, 2009 reaffirmed 2004, 2014)

PAs should recognize impairment in physician supervisors and other health providers and should seek assistance from any or all of the resources mentioned above to encourage these individuals to obtain treatment.

PAs as Medicaid Managed Care Providers (Adopted 1996, amended 1997, 2009, reaffirmed 2004, 2014)

Recommendations

PAs, practicing with physician supervision, are a critical part of the health workforce providing care for Medicaid patients. To facilitate the continued delivery of services to these patients, AAPA believes that states should include the following provisions in Medicaid managed care plans:

- PAs should be recognized as primary care providers, either by naming them individually, or in conjunction with their supervising physicians, or by naming them within a group.
- To maintain and improve continuity of care, PAs should be included on the list of health care professionals in order to allow Medicaid beneficiaries the option of seeking care from a physician-PA team that may in fact already be serving as their current provider of care.
- States should assign a maximum patient panel that recognizes the proven productivity of PAs and physicians and does not provide a disincentive for utilizing PAs on the health care team. This can be achieved by increasing a supervising physician's panel size by an appropriate number or by directly paneling the PA.
- State Medicaid programs should establish regulations that are consistent with PA state law to allow for the maximum efficiency of physician-PA teams.

Professional Competence (Adopted 1996, amended 2005, 2010, 2015)

Competence, Competencies and Competency-based Education

An overarching competency PAs must possess is the ability to practice interdependently in the physician/PA team: A skill that requires medical knowledge, professionalism, and interpersonal and communication skills, but is more than the sum of these parts.

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

Special Concerns for PAs

(95) The patient is the central figure in end-of-life decision making, but PAs have an important role to play. In some cases, the PA will be the dying patient's primary health care provider and chief advocate. All medical caregivers have a prime responsibility to ensure the patient's well-being. In doing so, however, they must act in accordance with their own ethical principles. PAs also have a unique responsibility arising from their relationship with supervising physicians, who share liability for the PA's actions.

(100) A PA has two supervising physicians who share call and hospital duties, but have widely divergent moral and/or ethical views on end-of-life issues.

(101) A precarious spot and divided loyalties may characterize the PA's position in such circumstances. The optimal course is to discuss end-of-life issues with the supervising physician before potential conflicts arise. When discord persists, the PA must remember that the physician bears the ultimate liability and, therefore, the final responsibility for clinical decision making. A PA who believes that legal or ethical precepts are being violated is responsible for speaking out in an appropriate and timely manner.

Conclusion
(109) PAs have a legal and ethical responsibility to the supervising physician, as well as to the patient. PAs should inform and involve the physician in all near-death planning. The PA should not withdraw life support without the supervising physician's agreement.

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

Introduction
When faced with an ethical dilemma, PAs may find the guidance they need in this document. If not, they may wish to seek guidance elsewhere, possibly from a supervising physician, a hospital ethics committee, an ethicist, trusted colleagues, or other AAPA policies.

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

Initiation and Discontinuation of Care
A PA and supervising physician may discontinue their professional relationship with an established patient as long as proper procedures are followed. The PA and physician should provide the patient with adequate notice, offer to transfer records, and arrange for continuity of care if the patient has an ongoing medical condition.

Disclosure
A PA should disclose to his or her supervising physician information about errors made in the course of caring for a patient. The supervising physician and PA should disclose the error to the patient if such information is significant to the patient's interests and well being.

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

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

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

Flexibility as a Hallmark of the PA Profession: The Case Against Specialty Certification
(Adopted 2002, reaffirmed 2007, amended 2012)

Value of PAs
Among the unique attributes of PAs are the focus, content, and length of their education, their socialization, and their adaptability in the delivery of medical services previously provided only by

physicians. PAs are also distinguished by their commitment to practice as part of physician-PA teams.

PA Education
PA 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.

PA Practice
By functioning as part of physician-directed teams, PAs have flexibility in practice. A supervising physician is authorized within the boundaries of state law or federal regulations, to delegate to the PA any portion of the physician's practice that are within the PA's ability to perform. 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.

… 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. 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.

Quality Incentive Programs (Adopted 2005, reaffirmed 2010, 2015)

Impact on PAs
Providing culturally effective care and employing strategies to increase patient adherence will improve patient outcomes. Education in transition management may be necessary to help PAs gently persuade some supervising physicians to make the necessary changes in practice.

Competencies for the PA Profession (Adopted 2005, reaffirmed 2010, amended 2013)

Introduction
This document serves as a map for the individual PA, the physician-PA team, and organizations committed to promoting the development and maintenance of professional competencies among PAs.

Patient-centered, PA practice reflects a number of overarching themes. These include an unwavering commitment to patient safety, cultural competence, quality health care, lifelong learning, and professional growth. Furthermore, the profession's dedication to the physician-PA team benefits patients and the larger community.

Professionalism
PAs are expected to demonstrate:

- understanding of legal and regulatory requirements, as well as the appropriate role of the PA
- professional relationships with physician supervisors and other health care providers

Systems-based Practice
PAs should work to improve the health care system of which their practices are a part. PAs are expected to:

- effectively interact with different types of medical practice and delivery systems
- understand the funding sources and payment systems that provide coverage for patient care and use the systems effectively
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities
- partner with supervising physicians, health care managers, and other health care providers to assess, coordinate, and improve the delivery and effectiveness of health care and patient outcomes

The Role of In-Store or Retail Health Clinics (Adopted 2007 and reaffirmed 2012)

Executive Summary

PAs have worked hard to overcome misconceptions about their abilities and the medical marketplace has demonstrated that physician-PA teams are capable of a wide range of services, including highly complicated specialty practice.

There are several principles that AMA, AAFP, and AAP believe should be followed by store-based clinics. The principles that the three organizations have in common are referrals of patients to physician practices in the community; use of evidence-based medical protocols; and compliance with relevant state laws regarding physician supervision or collaboration with PAs and NPs or some form of physician-directed team practice.

AAPA adopted a policy related to retail clinics in 2003 that says:

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

As a complement to this policy, AAPA proposes that retail clinics:

- Seek to establish arrangements by which their health care providers have ongoing access to and supervision by physicians (MDs and DOs), consistent with state laws;
- Seek to establish referral systems with physician practices or other facilities for appropriate treatment if the patient's condition is beyond the scope of services provided by the clinic; and
- Seek to establish formal connections with physician practices in the community to provide continuity of care and encourage a medical home for patients.

MODEL STATE LEGISLATION

Introductory Section

The model legislation does not propose that the regulatory authority approve or register collaborating physicians. Any licensed physician or group of physicians (MD or DO) may collaborate with a PA unless the physician's ability to collaborate has been limited by disciplinary action.

Definitions

"Collaborating physician" means an MD or DO licensed by the board who collaborates with PAs.

"Collaboration" means the process in which PAs and physicians jointly contribute to the healthcare and medical treatment of patients with each collaborator performing actions he or she is licensed or otherwise authorized to perform. Collaboration shall be continuous but shall not be construed to require the physical presence of the physician at the time and place that services are rendered.

Scope of Practice

PAs practice medicine in collaboration with physicians. PAs may provide any medical service that is within the PA's skills, education and training. This includes the ordering, prescribing, dispensing and administration of drugs and medical devices.

Collaboration

Collaboration shall be continuous, but shall not be construed to require the physical presence of the physician at the time and place that services are rendered. It is the obligation of each team of physician(s) and PA(s) to ensure that the PA's scope of practice is identified and appropriate to the PA's skill, education and training, and that the relationship with, and access to, the collaborating physician(s) is defined.

Collaborating Physician

A physician who collaborates with a PA must:

1. be licensed in this state;
2. be free from any restriction on his or her ability to collaborate with a PA that has been imposed by board disciplinary action.

A physician collaborating with a PA practicing in a federal jurisdiction is not required to meet the licensing requirements under this section, but must meet the licensing requirements of the federal agency.

Participation in Disaster and Emergency Care, Volunteering

A PA licensed in this state or licensed or authorized to practice in any other U.S. jurisdiction or who is credentialed as a PA by a federal employer who is responding to a need for medical care created by an emergency or a state or local disaster (not to be defined as an emergency situation that occurs in the place of one's employment) may render such care that they are able to provide without collaboration, as it is defined in this section of law or with such collaboration as is available.

Any physician who collaborates with a PA providing medical care in response to such an emergency or state or local disaster shall not be required to meet the requirements set forth in this section of law for a collaborating physician.

No PA licensed in this state or licensed or authorized to practice in other states of the United States who voluntarily and gratuitously, and other than in the ordinary course of employment or practice, renders

emergency medical assistance shall be liable for civil damages for any personal injuries that result from acts or omissions by those persons in rendering emergency care, which may constitute ordinary negligence. The immunity granted by this section shall not apply to acts or omissions constituting gross, willful or wanton negligence, or when the medical assistance is rendered at any hospital, physician's office or other healthcare delivery entity where those services are normally rendered. No physician who collaborates with a PA voluntarily and gratuitously providing emergency care as described in this subsection shall be liable for civil damages for any personal injuries that result from acts or omissions by the PA rendering emergency care.

A PA licensed in this state, or licensed or authorized to practice in any other U.S. jurisdiction, or who is credentialed by a federal employer or meets the licensure requirements of their requisite federal agency as a PA may volunteer to render such care that they are able to provide at a children's summer camp or for a public or community event without a collaborating physician as it is defined in this section of law or with such collaborating physicians as may be available. Such care must be rendered without compensation or remuneration. It is the obligation of the PA to assure adequate and appropriate professional liability coverage.