

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 6  
(I-20)

Introduced by: Joshua Lesko MD, Katie Marsh MD, Pratistha Koirala MD PhD, Dan Pfeifle MD, Hans Arora MD PhD, Gunjan Malhotra MD, Benjamin Meyer MD, Karen Dionesotes MD MPH, Michael Villareal MD MBA

Subject: Non-Physician Post-Graduate Medical Training

Referred to: Reference Committee

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Whereas, Data collected by AMA's Truth in Advertising campaign suggest nearly 90% of patients believe "only a medical doctor or doctor of osteopathic medicine should be able to use the title "physician."<sup>i</sup>; and

Whereas, In the same campaign, nearly 80% of patients "support legislation to require all health care advertising materials to clarify designate the level of education, skills and training of all health care professionals promising their services" <sup>ii</sup>; and

Whereas, The Center for Medicare and Medicaid Services defines resident as "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program including programs in osteopathy, dentistry, and podiatry as required to become certified by the appropriate specialty board"<sup>iii</sup>; and

Whereas, There has been an increase in the number of physician assistant (PA) and nurse practitioner (NP) postgraduate programs, many of which are inappropriately referred to as "residencies" or "fellowships"<sup>ivvvi</sup>; and

Whereas, On September 3rd 2020 every major academic emergency medicine association issued a joint statement affirming that "the terms 'resident,' 'residency,' 'fellow,' and 'fellowship' in a medical setting must be limited to postgraduate clinical training of medical school physician graduates within GME training programs"<sup>vii</sup>; and

Whereas, Several of these training programs pay their first year trainees more than the first year residents in physician residencies<sup>viii</sup>; therefore be it

RESOLVED, that our AMA support Nurse Practitioners (NPs) and Physician Assistants (PAs) pursuing post-graduate clinical training prior to practicing within a subspecialty; and be it further

RESOLVED, That our AMA supports pay equity among trainees within the healthcare team and believes that salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence allowed by an individual's training program; and be it further

RESOLVED, That our AMA recognizes that the terms "medical student," "resident," "residency," "fellow," "fellowship," "doctor," and "attending," when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians, thus these terms should be reserved to describe physician roles; and be it further

RESOLVED, That our AMA amend policy H-275.925 "Protection of the Titles "Doctor," "Resident" and "Residency" by addition as follows:

Our AMA: (1) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; (2) supports state legislation that would penalize misrepresentation of one's role in the physician-led healthcare team, up to and including to make it a felony to misrepresent oneself as a physician (MD/DO); and (3) supports state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training programs using the terms "medical student", "resident", "residency", "fellow", "fellowship", "doctor", or "attending" in a healthcare setting.; and be it further

RESOLVED, That policy H-310.912 "Resident and Fellow Bill of Rights" be amended by addition and deletion to read as follows:

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, all physicians in graduate medical education must be ultimately supervised only by physicians. Residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where physicians are immediately supervised by non-physicians there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate non-physician supervision to the training program, sponsoring institution, or ACGME as appropriate. ~~It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.~~; and be it further

RESOLVED, That our AMA will work with relevant stakeholders to define appropriate labels for post-graduate clinical and diagnostic training programs for non-physicians that recognizes the rigor of these programs but prevents role confusion associated with the terms "resident", "residency", "fellow", or "fellowship" and report back on the progress of this initiative by I-21; and be it further

RESOLVED, That our AMA partner with the ACGME to create standards requiring Program Directors and Designated Institutional Officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships; and be it further

RESOLVED, That our AMA study curriculum and accreditation requirements for postgraduate clinical training programs for non-physicians and report back at I-21 and biennially thereafter, on these standards, their accreditation bodies, their supervising boards, and the impact of non-physician graduate clinical education on physician graduate medical education; and be it further

RESOLVED, That our AMA study the current regulating, licensing, and certifying bodies governing Nurse Practitioners, Physicians Assistants, Certified Registered Nurse Anesthetists, and Anesthesia Assistants, including their geographic practice patterns; and be it further

RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians does not divert funding from physician GME; and be it further

RESOLVED, That our AMA object to the ABMS and its member boards having designated seats for Nurse Practitioners, Physicians Assistants, Certified Registered Nurse Anesthetists, or Anesthesia Assistants that are independent from the public member seats; and be it further

RESOLVED, That the above resolved clauses be immediately forwarded to the 2020 House of Delegates Special Meeting; and be it further

RESOLVED, That AMA-RFS policy 380.002R ("Independent Practice of Medicine") be amended by addition and deletion to read as follows:

That our AMA-RFS support: (1) working at the local, state, and federal levels of government, ~~through both legislation and regulation, to prevent the independent practice of medicine by non-physicians; mid-level health care providers, as medicine should only be practiced by a fully licensed physician qualified by reason of education, training, and experience in such practice;~~ and (2) ~~reimbursement models that working toward regulation and legislation that create reimbursement models do not reimburse non-physicians mid-level providers at the same rates as physicians, and (3) legislation requiring all healthcare providers to clearly identify their credentials to patients, including specifically identifying whether or not they are a physician.~~; and be it further

RESOLVED, That our AMA-RFS rescind policies 40.002R ("Mid-Level Practitioner Tracking System), 380.003R ("Proper identification of Health Care Providers"), and 380.004R ("Scope of Practice of Mid-Level Providers").

Fiscal Note:

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#### References:

- <sup>i</sup> <https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf>
- <sup>ii</sup> <https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf>
- <sup>iii</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf>
- <sup>iv</sup> <https://www.aaem.org/resources/statements/position/em-training-programs-for--pas-and-nps>
- <sup>v</sup> <https://appap.org/wp-content/uploads/2020/03/APPAP-Postgraduate-Program-Membership-Roster-by-Specialty-March-2020.pdf>
- <sup>vi</sup> 12. Association of Postgraduate Physician Assistant Programs. APPAP programs by specialty. Accessed at <http://appap.org/Programs/tabid/58/Default.aspx> on January 30, 2010.
- <sup>7</sup> <https://architectinperson.wordpress.com/2011/11/16/stop-calling-me-the-intern/>
- <sup>vii</sup> <https://www.emra.org/be-involved/be-an-advocate/working-for-you/post-grad-statement-pa-np/>, accessed 9/12/2020
- <sup>viii</sup> <https://med.dartmouth-hitchcock.org/pa-residency/ccappresidency.html>

#### Relevant RFS Position Statements:

##### **380.002R Independent Practice of Medicine**

That our AMA work at the local, state, and federal levels of government, through both legislation and regulation, to prevent the independent practice of medicine by mid-level health care providers, as medicine should only be practiced by a fully licensed physician qualified by reason of education, training, and experience in such practice, and that our AMA work toward regulation and legislation that create reimbursement models do not reimburse mid-level providers at the same rates as physicians. (Resolution 8, A-11)

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**40.002R Mid-Level Practitioner Tracking System**

That our AMA-RFS support AMA policy to promote and encourage the tracking of mid-level practitioners for the purpose of identifying underserved rural areas. (Resolution, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

**380.003R Proper identification of Health Care Providers**

That our AMA support state medical boards and state medical societies in adopting advisory opinions and advancing legislation requiring all healthcare providers to clearly identify their credentials to patients. (Resolution 9, A-11)

**380.004R Scope of Practice of Mid-Level Providers**

That our AMA-RFS oppose the independent practice of mid-level providers in the interest of patient safety and provider competency. (Resolution 3, A-10)

**Relevant AMA Policy:****H-310.912 "Resident and Fellow Bill of Rights"****H-275.925 Protection of the Titles "Doctor," "Resident" and "Residency"**

Our AMA: (1) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (2) supports state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO).

*Sub. Res. 232, A-08; Reaffirmation I-09; Reaffirmed: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 09, A-19*

**D-160.995 Physician and Nonphysician Licensure and Scope of Practice**

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.

2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.

3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.

*CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19*

**H-270.958 Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners**

1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities.

2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full

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authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

*BOT Action in response to referred for decision Res. 902, I-06; Reaffirmed: BOT Rep. 06, A-16*

#### **D-35.996 Scope of Practice Model Legislation**

Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners.

*Res. 923, I-03 Reaffirmed: BOT Rep. 28, A-13*

#### **H-160.950 Guidelines for Integrated Practice of Physician and Nurse Practitioner**

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.

(2) The physician is responsible for managing the health care of patients in all practice settings.

(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.

(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.

(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.

(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.

(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.

(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.

(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.

(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

*CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13*

#### **Code of Medical Ethics: 10.5 Allied Health Professionals**

Physicians often practice in concert with optometrists, nurse anesthetists, nurse midwives, and other allied health professionals. Although physicians have overall responsibility for the quality of care that patients receive, allied health professionals have training and expertise that complements physicians'. With physicians, allied health professionals share a common commitment to patient well-being.

In light of this shared commitment, physicians' relationships with allied health professionals should be based on mutual respect and trust. It is ethically appropriate for physicians to:

(a) Help support high quality education that is complementary to medical training, including by teaching in recognized schools for allied health professionals.

(b) Work in consultation with or employ appropriately trained and credentialed allied health professionals.

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(c) Delegate provision of medical services to an appropriately trained and credentialed allied health professional within the individual's scope of practice.

*AMA Principles of Medical Ethics: I, V, VII*

**D-160.993 Limitation of Scope of Practice of Certified Registered Nurse Anesthetists**

Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.

*Res. 220, I-01 Reaffirmed: CMS Rep. 7, A-11*

**D-275.979 Non-Physician "Fellowship" Programs**

Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.

*CME Rep. 4, I-04; Reaffirmed: CME Rep. 2, A-14*

**D-160.993 Limitation of Scope of Practice of Certified Registered Nurse Anesthetists**

Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.

*Res. 220, I-01; Reaffirmed: CMS Rep. 7, A-11*