AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 329
(A-22)

Introduced by: Texas

Subject: Use of the Terms “Residency” and “Fellowship” by Health Professions Outside of Medicine

Referred to: Reference Committee C

Whereas, The terms “residency” and “fellowship” have historical and valued meaning within American medicine, dating back more than 100 years. In 1889 at Johns Hopkins Hospital, William Osler, MD, established America's first formal residency program with interns and residents residing in the hospital. Fellows stayed for additional years of training, and these roles and references remain relevant; and

Whereas, Physicians pursuing specialty board certification are required to complete standardized and accredited training referred to as residency, with the possibility for further sub-specialized training referred to as fellowship; and

Whereas, Some postgraduate training programs for nonphysician clinicians, including podiatrists, pharmacists, advanced practice registered nurses, and psychologists have started using the same nomenclature, labeling their programs as residencies and fellowships; and

Whereas, The curricula for postgraduate medical training programs are well-defined and standardized through a national accreditation process and informed by board-certification requirements. The postgraduate training pathways for other health professionals do not require the same rigor as medicine. They often are not standardized, and the content is vastly more limited than medicine in depth, scope, and duration. The broad application of these terms to a diversity of programs without the same complexity of training creates the potential for misconceptions among the general public; and

Whereas, Using these terms to blur the lines between the training of physicians and other health professions do not accurately reflect the distinctions between the training models and can demean the definition of the field of medicine. These misconceptions also are used to support scope-of-practice expansions in health professions outside medicine; and

Whereas, A survey of the public revealed confusion about which clinicians have medical degrees or degrees of osteopathic medicine, and favored transparency of training; and

Whereas, The American Academy of Dermatology has stated that labeling nonphysician training programs as residencies or fellowships is misleading and this terminology should apply only to physician training programs; and

Whereas, In the patient care setting, the role of individual health care practitioners should be clearly identified to patients and other health care practitioners. Name tags that identify residents or fellows as physicians distinguishes them from other health care practitioners and clarifies their role on the health care team; and

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Whereas, The American Academy of Emergency Medicine has stated that training programs for physician assistants and advanced practice registered nurses should avoid use of the terms resident and fellow; and

Whereas, A national discussion by the American Medical Association is needed to prevent the continued distortion of these terms by nonphysician groups; therefore be it

RESOLVED, That our American Medical Association hold a national discussion about the historical value and current nature of the terms “residency” and “fellowship” to describe physician postgraduate training and address the ramifications of nonphysician clinician groups using similar nomenclature that can confuse the general public. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/22

The topic of this resolution is currently under study by the Council on Medical Education.

References:

1. A History of Medical Residency
2. Truth in Advertising survey results
3. AAEM and AAEM/RSA Position Statement on Emergency Medicine Training Programs for Non-Physician Practitioners
4. Position Statement on Dermatology Residency and Fellowship Training Nomenclature Exclusivity for U.S. Based Dermatology Residents and/or Fellows

RELEVANT AMA POLICY

Non-Physician "Fellowship" Programs D-275.979
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.
Citation: (CME Rep. 4, I-04; Reaffirmed: CME Rep. 2, A-14)

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

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(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.
Citation: (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)

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