Both sets of standards help underscore that interprofessional education is a priority in medical education. That said, these standards could be expanded and strengthened to state that physicians' education and training make them uniquely qualified to lead the health care team, as reflected in AMA policy. In addition, it would be within the scope of the AMA to advocate for insertion of qualifying modifiers in these standards where warranted—for example, inclusion of the phrase "physician-led" to modify "interprofessional teams." This report includes a recommendation to that effect. Personal communication with LCME staff indicates that this change would be appropriate.

While interprofessional education is important, residency programs and their sponsoring institutions need to ensure that the presence of other health professionals in the clinical setting does not negatively impact resident education, including ensuring that residents have the appropriate responsibility for patient care, case numbers, and case mix to prepare them for independent practice. The ACGME's Common Program Requirements state, in this regard, that "The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education."[10] This concept is reflected in Policy H-310.913, "Physician Extenders," which notes in part that "procedural training is a critical portion of resident education and the augmentation of patient care by nonphysician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures."

Education and training of other health professionals

The AMA does not directly oversee the education and training of nonphysician health care professionals. For several decades, beginning in the 1930s, the Council on Medical Education did have oversight over accreditation of a significant number of allied health education programs including physician assistants through its Committee on Allied Health Education and Accreditation, or CAHEA. By the early to mid-1990s, that work was seen as outside the scope of the AMA and ceased, leading to development of the Commission on Accreditation of Allied Health Education Programs and other accreditation bodies to continue this essential role.

Despite this lack of direct oversight, the AMA can call on standard-setting organizations, such as the American Board of Medical Specialties, to play a more active role in communicating with policymakers the standards to which physicians are held, including maintenance of certification, and why these standards serve as the basis for physician leadership of the health care team.

Resolves 3 and 4 of the referred resolution encompass AMA study of establishing "mandatory postgraduate clinical training for nurse practitioners and physician assistants prior to working within a specialty or subspecialty field" and "national requirements for structured and regulated continued education for nurse practitioners and physician assistants in order to maintain licensure to practice."

For NPs, five different certifying bodies offer 19 different certificates in various fields of medicine.[11] Certification is required to obtain state licensure for practice as an NP. Similarly, PAs seeking to practice must obtain the PA-C certification. In addition, the National Commission on Certification of Physician Assistants currently offers 10 certificates of added qualifications (CAQs) in various fields (the CAQ is a voluntary credential and does not replace PA-C certification).[12] To obtain one of these CAQs, a PA-C must have between 2 to 4 years of experience in the field. Since 2011, nearly 2,800 PA-Cs have earned CAQs in seven different specialties.

In summary, the third and fourth Resolves of the referred resolution are neither feasible nor enforceable as our AMA does not have the authority or purview over post-graduate clinical training or continuing education requirements for nonphysicians. These requirements are set by the individual profession's accrediting, certifying, and licensing bodies. In addition, the AMA does not have the ability to conduct a study on harms and benefits of additional training and certification requirements for NPs and PAs to work as licensed professionals.

(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. 2-12; Reaffirmed: BOT Rep. 16, A-13)

H-160.906, "Models / Guidelines for Medical Health Care Teams"

1. Our AMA defines 'physician-led' in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

Patient-Centered:
a. The patient is an integral member of the team.
b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
d. Team members are expected to adhere to agreed-upon practice protocols.
e. Improving health outcomes is emphasized by focusing on health as well as medical care.
f. Patients' access to the team for coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
g. Safety protocols are developed and followed by all team members.

Teamwork:
h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
i. All practitioners commit to working in a team-based care model.
j. The number and variety of practitioners reflects the needs of the practice.
k. Practitioners are trained according to their unique function in the team.
l. Interdependence among team members is expected and relied upon.
m. Communication about patient care between team members is a routine practice.
n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.
Clinical Roles and Responsibilities:
o. Physician leaders are focused on individualized patient care and the development of treatment plans.
p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
q. Care coordination and case management are integral to the team's practice.
r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:
s. Electronic medical records are used to the fullest capacity.
t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.
u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

(CMS Rep. 6, A-14; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 05, A-17)

H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice"

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.H-35.

(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.

(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.

(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.

(5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.

(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

(BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13)

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.
(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
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

(Issued: 2016)

H-35.989, “Physician Assistants”

1. Our AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.

2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.

3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.

4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.

5. The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.

6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.

7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.

(BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 230, I-17)

H-160.947, "Physician Assistants and Nurse Practitioners"

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

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

(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.

(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.

(4) The physician is responsible for the supervision of the physician assistant in all settings.

(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.

(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

(BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)

H-310.913, "Physician Extenders"

1. In academic environments, our AMA will only support payment models for non-physician practitioners that do not interfere with graduate medical training.
2. Our AMA supports the concept that procedural training is a critical portion of resident education and the augmentation of patient care by non-physician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures.
(Res. 208, I-10; Appended: CME Rep. 8, A-13)

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