WHEREAS, A primary concern of our American Medical Association is both the improvement of medical care and public health, as well as the satisfaction of the physician in the practice of medicine; and

WHEREAS, Our AMA has concerns about the expanding scope of practice of non-physician practitioners; and

WHEREAS, Our AMA has policy on the supervision of physicians by physicians (AMA Policy H-375.967) with the purpose of assuring the greatest quality and safety of patients under medical care; and

WHEREAS, Our AMA has policy that states, “The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions.” As this policy suggests guidelines that should be included in medical staff bylaws but is incomplete in defining the extent and limitations of physician supervision of non-physician practitioners (AMA Policy H-35.996); therefore be it

RESOLVED, That our American Medical Association advocate to relevant entities with a goal to ensure physicians on staff receive written notification when their license is being used to document “supervision” of non-physician practitioners. Physician supervision should be explicitly defined and mutually agreed upon (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for advanced notice and disclosure to the physician before they are hired or as soon as practicably known by provider organizations and institutions that anticipate physician supervision of non-physician practitioners as a condition for physician employment (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that organizations, institutions, and medical staffs that have physicians who participate in supervisory duties for non-physician practitioners have processes and procedures in place that have been developed with appropriate clinical physician input. These should be adequate to assure patient safety and appropriate clinical care and are fully disclosed to physicians (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections so as not to be retaliated against by the physician’s employer in any way (Directive to Take Action).
Fiscal Note: Minimal: Less than $1,000 to implement

Received: 10/2/2022
RELEVANT AMA POLICY

Supervision and Proctoring by Facility Medical Staff (H-375.967)

Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:

1. Physicians serving as medical staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function.
2. Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.
3. AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.
4. The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.
5. The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.
6. The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.
7. Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.
8. Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcripted by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.
9. Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports.

Citation: CMS Rep. 3, A-99; Reaffirmed: CLRDPD Rep. 1, A-09; Reaffirmed: CMS Rep. 01, A-19

Status and Utilization of New or Expanding Health Professionals in Hospitals (H-35.996)

1. The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff. Thus this statement covers regulation of such categories as the new physician-support occupations generically termed physician assistants, nurse practitioners, and those allied health professionals functioning in an expanded medical support role.
(2) The hospital governing authority should depend primarily on the medical staff to recommend
the extent of functions which may be delegated to, and services which may be provided by,
members of these emerging or expanding health professions. To carry out this obligation, the
following procedures should be established in medical staff bylaws: (a) Application for use of
such professionals by medical staff members must be processed through the credentials
committee or other medical staff channels in the same manner as applications for medical staff
membership and privileges. (b) The functions delegated to and the services provided by such
personnel should be considered and specified by the medical staff in each instance, and should
be based upon the individual's professional training, experience, and demonstrated
competency, and upon the physician's capability and competence to supervise such an
assistant. (c) In those cases involving use by the physician of established health professionals
functioning in an expanded medical support role, the organized medical staff should work
closely with members of the appropriate discipline now employed in an administrative capacity
by the hospital (for example, the director of nursing services) in delineating such functions.

00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 1, A-22

Practicing Medicine by Non-Physicians (H-160.949)

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences
of any health care plan that places any patient care at risk by substitution of a non-physician in
the diagnosis, treatment, education, direction and medical procedures where clear-cut
documentation of assured quality has not been carried out, and where such alters the traditional
pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in
the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the
practice of medicine without physician (MD, DO) training or appropriate physician (MD,
DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-
physician groups to engage in the practice of medicine without physician (MD, DO) training or
appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the
requirement of appropriate physician supervision of non-physician clinical staff in all areas of
medicine; and
(6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not
currently enrolled in an Accreditation Council for Graduate Medical Education training program,
or have not completed at least one year of accredited graduate medical education in the U.S).

Citation: Res. 317, I-94; Modified: Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmed: A-99;
Appended: Res. 240, Reaffirmed: Res. 708 and reaffirmation, A-00; Reaffirmed: CME Rep. 1, I-
00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 334, A-11;
Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 342, A-14;
Modified: CME Rep. 2, A-21
Support for Physician Led, Team Based Care (D-35.985)

Our AMA:


2. Will identify and review available data to analyze the effects on patients’ access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.

3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.

4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation’s primary care workforce needs.

5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.

6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.

7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.