Whereas, patients seeking emergency medical care should seek care at facilities prepared to offer evaluation and medical diagnosis of undifferentiated acute symptoms, recognition and stabilization of emergency conditions, appropriate emergency treatment when available and/or transfer to a higher level of care for emergency conditions when appropriate; and

Whereas, facility designations using the term “emergency” within their title may be assumed by laypersons or medical professionals to imply the ability to offer all of the above emergency duties and services; and

Whereas, the shift from “supervision” to “collaboration” of non-physician practitioners (NPPs) (e.g., APRNs, PAs, and CRNAs), may imply a lower degree of physician involvement in the care of the patient in as much as, collaboration may imply mere consultation of the physician only when deemed necessary by the NPP which is inadequate in the setting of acute medical care because NPPs have not been trained in the great breadth of medicine, as have physicians, and cannot consistently recognize all acute emergency situations in which immediate physician care is required; and

Whereas, every patient presenting to a facility which represents itself as a place where patients can seek emergency medical care should be under the direct and real-time care of a licensed physician including the on-site and real-time supervision of NPPs; and

Whereas, despite an overall physician deficit, there is not a lack of emergency medicine (EM) physician workforce as there is a predicted surplus of EM physicians by the year 2030; therefore be it

RESOLVED, that our American Medical Association develop model state legislation and support federal and state legislation or regulation requiring all facilities that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and on-site supervision of non-physician practitioners (e.g., physician assistants and advanced practice nurses) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that emergency department. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 9/26/23
RELEVANT AMA POLICY

Physician and NonPhysician Licensure and Scope of Practice D-160.995

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/CLRDP Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19]

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

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. (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) Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards. (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; Modified: BOT Rep. 12, A-23 Reaffirmed: BOT Rep. 09, A-23]