AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(N-21)

Introduced by: Resident and Fellow Section

Subject: Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers

Referred to: Reference Committee B

Whereas, Patients are often not explicitly informed when seeking medical care what the qualifications are of the person treating them[1]; and

Whereas, Physicians are being forced or coerced into "supervising" midlevel providers either directly or indirectly, by using it as a requirement for physician employment[1]; and

Whereas, Physicians are being asked to "supervise," in name only, unreasonably high numbers of midlevel providers opening them up to liability issues[1]; and

Whereas, There have been instances where physicians' licenses have been used, unbeknownst to the physician, to document "supervision" of midlevel providers and also instances where midlevel providers do not even know the identity of their documented "supervising" physician[1]; and

Whereas, Midlevel providers/non-physicians have pushed for changes in legislation requiring "supervision" by physicians be changed to "collaboration" with physicians in effort to equate their training[1]; therefore be it

RESOLVED, That our American Medical Association reaffirm Policies H-160.947 and H-160.950 (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to "supervise" midlevel providers (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose mandatory physician supervision of midlevel providers as a condition for physician employment and in physician employment contracts, especially when physicians are not provided adequate resources and time for this responsibility (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the right of physicians to deny "supervision" to any midlevel provider whom they deem a danger to patient safety and the ability to report unsafe care provided by mid-levels to the appropriate regulatory board with whistleblower protections for physician employment. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/21/12

AUTHORS STATEMENT OF PRIORITY

Physicians, as leaders of the health care team, are often called on to supervise other members, including midlevel providers. However, physicians should be notified explicitly when their license is being used to supervise midlevel providers, not be forced to do so as a condition of employment and be able to advocate for the safety of their patients by reporting midlevel providers who are deemed a danger to patients to the appropriate regulatory board.

References:
1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020

RELEVANT AMA POLICY

Physician Assistants and Nurse Practitioners H-160.947
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.
Citation: 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

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.
(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)