

### Support

- On-site physician supervision of all non-physicians performing medical procedures including those for cosmetic indications.
- Quality care by ensuring adequately trained non-physicians.
- Clear and transparent communication with the patient about who will be providing care.

### Oppose

- Independent practice of non-physicians outside of a physician-led team.
- Physicians overseeing procedures outside of their scope of practice and for which they have no training and/or expertise.

**The guiding principle for all dermatologic surgeons is to practice ethical medicine with the highest possible standards.** Physicians should be properly trained in all procedures performed to ensure the highest level of patient care and safety. A physician should be fully qualified by residency training and fellowship or appropriate post-graduate training. Training should include an extensive understanding of cutaneous medicine and surgery, the indications for each procedure, and the pre- and post-operative care involved in treatment. Physicians should only claim subspecialization for treatments, conditions, or procedures within the scope of the residency or fellowship training which the physician completed, as described above. The physician may use terms in plain-English – or in languages spoken by patients – to describe the physician’s subspecialty so long as the description includes treatments, conditions or procedures within the residency training.

**Under the appropriate circumstances, a physician may delegate certain procedures to non-physicians.** Ideally, a physician should make the initial assessment of a patient. The supervising physician shall be physically present on-site, immediately available, and able to respond promptly to any question or problems that may occur while the procedure is being performed. It is the responsible physician’s obligation to ensure that a non-physician possesses knowledge of cutaneous medicine, documented training in the procedure, the indications for the procedure, and the pre- and post-operative care involved.

**Non-physicians, namely physician assistants (PAs) and Nurse Practitioners (NPs), are being implemented in medical settings to improve patient access to care.** Historically, non-physicians were introduced as a solution to the growing need for primary care services, especially in underserved areas. As such, there is a lack of formal education and specialty training. The clinical training of these non-physicians includes approximately 500-900<sup>1</sup> hours that spans across a number of medical specialties, of which only a small percentage is cutaneous medicine and surgery, compared to the nearly 10,000 hours of specialized training in the structure, function, and treatment of skin that dermatologists receive in their 3-year residency. In a study of dermatologists using non-physicians in their practice, only 10% of respondents said their PAs or NPs had received formal dermatology training, and just over half had completed a dermatology rotation during their education.<sup>2</sup>

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<sup>1</sup> Jalian, H.R., C.A. Jalian, and M.M. Avram. *Increased risk of litigation associated with laser surgery by nonphysician operators.* JAMA Dermatol, 2014. **150**(4): p. 407-11.

<sup>2</sup> Hibler B, Rossi A. *The Use of Non-physicians in Cosmetic Dermatology: Legal and Regulatory Standards.* Current Dermatology Reports, **2015**: p. 1-8

**Patients are often confused about who is performing their medical procedures. The alphabet soup of letters after a practitioner's name is confusing for patients who lack familiarity with their degrees and exact level of training they represent.** In an American Medical Association survey of patients, 39% of respondents thought that a doctor of nursing was a physician<sup>3</sup>. The use of clear terminology and transparency lessens the likelihood of misunderstandings. ASDSA supports public policy which requires staff directly interacting with patients to wear photo identification listing the individual's name and level of licensure using clear, complete terminology rather than hard to understand acronyms or abbreviations. Likewise, medical advertisements should list the name of persons performing treatments as well as one's level of licensure in similarly clear and complete terminology.

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**Additional References:**

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- Brody, H.J., R.G. Geronemus, and P.K. Farris, *Beauty versus medicine: the nonphysician practice of dermatologic surgery*. Dermatol Surg, 2003. **29**(4): p. 319-24.
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<sup>3</sup> Global Strategy Group conducted a telephone survey of 850 adults nationwide on behalf of the AMA Scope of Practice Partnership, Aug. 13–18, 2008. The overall margin of error is +/- 3.4 percent at the 95 percent confidence level. Baseline & Associates conducted a follow-up telephone survey of 850 adults nationwide on behalf of the Scope of Practice Partnership, Nov. 4–8, 2010. The overall margin of error is +/- 3.4 percent at the 95 percent confidence level. Baseline & Associates conducted an internet survey of 801 adults on behalf of the AMA Scope of Practice Partnership between May 1–June 6, 2014. The overall margin of error is +/- 3.5 percent at the 95 percent confidence level. Baseline & Associates conducted an internet survey of 802 adults on behalf of the AMA Scope of Practice Partnership, July 12-19, 2018. The overall margin of error is +/- 3.5 percent at the 95 percent confidence level. –for more information visit: <https://www.ama-assn.org/system/files/2020-10/truth-in-advertising-campaign-booklet.pdf>

<sup>4</sup> Be aware that each state / territory has its own set of laws and regulations that determine the delegation standards one must adhere to.

## Relevant AMA Policy:

### H-160.949 Practicing Medicine by Non-Physicians

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.).(Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation 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. 224, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21)

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

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.(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; Reaffirmed: BOT Rep. 09, A-23)

## **H-475.986 Surgical Assistants other than Licensed Physicians**

Our AMA: (1) affirms that only licensed physicians with appropriate education, training, experience and demonstrated current competence should perform surgical procedures;

(2) recognizes that the responsible surgeon may delegate the performance of part of a given operation to surgical assistants, provided the surgeon is an active participant throughout the essential part of the operation. Given the nature of the surgical assistant's role and the potential of risk to the public, it is appropriate to ensure that qualified personnel accomplish this function;

(3) policy related to surgical assistants states: (a) The surgical assistant is limited to performing specific functions as defined in the medical staff bylaws, rules and regulations. These generally include the following tasks: aid in maintaining adequate exposure in the operating field, cutting suture materials, clamping and ligating bleeding vessels, and, in selected instances, actually performing designated parts of a procedure. (b) It is the surgeon's responsibility to designate the individual most appropriate for this purpose within the bylaws of the medical staff. The first assistant to the surgeon during a surgical operation should be a credentialed health care professional, preferably a physician, who is capable of participating in the operation, actively assisting the surgeon. (c) Practice privileges of individuals acting as surgical assistants should be based upon verified credentials and the supervising physician's capability and competence to supervise such an assistant. Such privileges should be reviewed and approved by the institution's medical staff credentialing committee and should be within the defined limits of state law. Specifically, surgical assistants must make formal application to the institution's medical staff to function as a surgical assistant under a surgeon's supervision. During the credentialing and privileging of surgical assistants, the medical staff will review and make decisions on the individual's qualifications, experience, credentials, licensure, liability coverage and current competence. (d) If a complex surgical procedure requires that the assistant have the skills of a surgeon, the surgical assistant must be a licensed surgeon fully qualified in the specialty area. If a complication requires the skills of a specialty surgeon, or the surgical first assistant is expected to take over the surgery, the surgical first assistant must be a licensed surgeon fully qualified in the specialty area.(e) Ideally, the first assistant to the surgeon at the operating table should be a qualified surgeon or resident in an education program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and/or the American Osteopathic Association (AOA). Other appropriately credentialed physicians who are experienced in assisting the responsible surgeon may participate when a trained surgeon or a resident in an accredited program is not available. The AMA recognizes that attainment of this ideal in all surgical care settings may not be practicable. In some circumstances it is necessary to utilize appropriately trained and credentialed unlicensed physicians and non-physicians to serve as first assistants to qualified surgeons.(BOT Rep. 32, A-99; Reaffirmed: Res. 240, 708, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13; Modified: BOT Rep. 09, A-23)