American Society for Dermatologic Surgery ASSOCIATION

Position on Delegation

Support

- Direct on-site supervision of non-physician providers
- Quality care by ensuring adequately trained providers
- Clear and transparent communication with the patient about who will be providing care

Oppose

- Independent practice of non-physician providers 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. Under the appropriate circumstances, a physician may delegate certain procedures to non-physician providers. Ideally, the physician should make the initial assessment of a patient. However, the physician must directly supervise the non-physician providers to protect the best interests and welfare of each patient. The supervising physician shall be physically present on-site, immediately available, and able to respond promptly to any question or problem that may occur while the procedure is being performed. It is the responsible physician's obligation to ensure that the non-physician providers possess knowledge of cutaneous medicine, documented training in the procedure, the indications for the procedure, and the pre- and post-operative care involved.

Non-physician providers, namely physician assistants (PAs) and Nurse Practitioners (NPs), are being implemented in medical settings to improve patient access to care. Historically, non-physician providers 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 providers includes approximately 500-900[1] 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-physician providers 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.[2]

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[1] 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.

[2] 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 familiarization regarding these degrees and exact level of training they represent. As a result, legislation has been proposed to require the use of name badges and precise titles by all personnel. In an American Medical Association survey of patients, 35% of respondents thought that a doctor of nursing was a physician[3]. Laws and regulations have been recommended to enforce standards for physicians and non-physicians to clearly and honestly disclose their training and qualifications as well as accurately list the procedures they may legally perform that are within their scope of practice.

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Additional References:

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Choudhry, S., et al., *State medical board regulation of minimally invasive cosmetic procedures.* J Am Acad Dermatol, 2012. **66**(1): p. 86-91.

Moshell, A.N., P.D. Parikh, and W.J. Oetgen, *Characteristics of medical professional liability claims against dermatologists: data from 2704 closed claims in a voluntary registry.* J Am Acad Dermatol, 2012. **66**(1): p. 78-85.

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.

Friedman, P.M., et al., *Nonphysician practice of dermatologic surgery: the Texas perspective.* Dermatol Surg, 2004. **30**(6): p. 857-63.

Jalian, H.R., C.A. Jalian, and M.M. Avram, *Common causes of injury and legal action in laser surgery.* JAMA Dermatol, 2013. **149**(2): p. 188-93.

[3] 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. Baselice & 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. Baselice & 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. –for more information visit: http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/truth-in-advertising.page

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 physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.(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)

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)

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, consistent with the American College of Surgeons’ Statements on Principles 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)