Position on the Regulation of Physician Assistants

Support:

- Maintaining the authority of medical licensing and regulatory boards to regulate medicine through oversight of physicians, physician assistants and related medical personnel.

Oppose:

- The establishment of autonomous physician assistant regulatory boards outside of the medical board authority and purview.

In the interest of protecting patient safety, the authority to license, regulate and discipline physician assistants should be under the jurisdiction of existing state medical licensing and regulatory boards. Originally created in the mid 1960's[1] to support physicians and help alleviate primary care shortages, the physician assistant profession was designed to function under the direction and supervision of a duly qualified licensed physician. American Medical Association (AMA) policy states that the extent of the involvement of a physician assistant in the assessment and implementation of treatment should be determined by the supervising physician.[2] AMA policy also states that a physician assistant should provide patient care only in accordance with the state's medical practice act and other state law, and such law should provide that the physician assistant's utilization be approved by the medical licensing board.[3] ASDSA believes that in order to ensure patient safety and quality care, the practice of medicine[4] should only be performed by licensed physicians and their properly trained and qualified delegates under the direct, on-site supervision of a licensed physician.[5] As physicians are licensed, regulated and disciplined by state medical licensing and regulatory bodies and are ultimately responsible for the scope of the physician assistant's duties, physician assistant licensure, regulation and disciplinary action should be under the jurisdiction of the state medical licensing board. Currently, the majority of states authorize the medical licensing boards to license, regulate and discipline physician assistants.[6]

Approved by the ASDSA Board of Directors: May 2017
Updated January 2020

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[1] History of the Profession - Physician Assistant Program | Boston University. (n.d.). Retrieved March 07, 2017, from https://www.bu.edu/paprogram/pa-profession/history-of-the-profession/

[2] AMA Policy Finder*: Physician Assistants and Nurse Practitioners* H-160.947 – 2013 https://searchpf.ama-assn.org/SearchML/searchDetails.action?uri=%2FAMADoc%2FHOD.xml-0-761.xml

[3] AMA Policy Finder: *Physician Assistants* H-35.989 - 2011 https://searchpf.ama-assn.org/SearchML/searchDetails.action?uri=%2FAMADoc%2FHOD.xml-0-2996.xml

[4] ASDSA *Position Statement on the Definition of the Practice of Medicine* - http://asdsa.asds.net/uploadedFiles/ASDSA/Policymakers/ASDSA-Definition%20of%20the%20Practice%20of%20Medicine.pdf

[5] ASDSA *Position Statement on Delegation* – http://asdsa.asds.net/uploadedFiles/ASDSA/Policymakers/ASDSA-%20Delegation%20Position%20Statement(1).pdf

[6] FSMB. (2016). U.S. Medical Regulatory Trends and Actions. Retrieved March 7, 2017, from https://www.fsmb.org/Media/Default/PDF/FSMB/Publications/us_medical_regulatory_trends_actions.pdf

Related AMA Policy:

H-160.947 Physician Assistants and Nurse Practitioners

Our AMA:

1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.

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.
(BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19)

H-35.989 Physician Assistants

1. Our AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.

2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the

qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.

3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.

4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.

5. The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.

6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.

7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.
(BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 230, I-17)