

REPORT OF THE BOARD OF TRUSTEES

B of T Report 24 - A-06

Subject: Limited Licensure Health Care Provider Training and
Certification Standards

Presented by: Duane M. Cady, MD, Chair

1 INTRODUCTION

2
3 At the 2005 American Medical Association (AMA) Interim Meeting, the House of Delegates
4 (HOD) adopted as amended Resolution 814 entitled “Limited Licensure Health Care Provider
5 Training and Certification Standards.” Resolution 814 calls on the AMA, along with the Scope of
6 Practice Partnership (SOPP) and interested Federation partners, to study the qualifications,
7 education, academic requirements, licensure, certification, independent governance, ethical
8 standards, disciplinary processes, and peer review of the limited licensure health care providers and
9 limited independent practitioners, as identified by the SOPP.

10
11 Testimony before the Reference Committee and HOD was generally supportive of this resolution.
12 Testimony also indicated that the SOPP Steering Committee had identified a study similar to the
13 one called for in Resolution 814 as one of its first priorities, once the SOPP had officially come
14 into existence. The Reference Committee concurred with the testimony presented that the issue
15 raised in Resolution 814 was one to be addressed as soon as possible. As a result, the Reference
16 Committee recommended that the initial resolve be modified to reflect the involvement of the
17 SOPP in conducting the study called for in Resolution 814. However, the Reference Committee,
18 noting the extensive nature of Resolution 814’s study, indicated that it “under[stood] that a report
19 back at the 2006 Annual Meeting may only be a preliminary update on the Partnership’s progress
20 on this issue.” The HOD voted, therefore, to have the AMA report back at the A-06.

21 RELEVANT AMA POLICY

22
23
24 The AMA has extensive policy related to scope of practice issues. A sampling of AMA policies
25 most relevant to Resolution 814 are as follows:

- 26
- 27 • E-3.03 – Allied Health Professionals (AMA Policy Database). E-3.03 states that “[p]hysicians
28 often practice in concert with allied health professionals such as, but not limited to,
29 optometrists, nurse anesthetists, nurse midwives, and physician assistants in the course of
30 delivering appropriate medical care to their patients. In doing so, physicians should be guided
31 by the following principles: (1) It is ethical for a physician to work in consultation with or
32 employ allied health professionals, as long as they are appropriately trained and duly licensed
33 to perform the activities being requested. (2) Physicians have an ethical obligation to the
34 patients for whom they are responsible to ensure that medical and surgical conditions are
35 appropriately evaluated and treated. (3) Physicians may teach in recognized schools for the
36 allied health professionals for the purpose of improving the quality of their education. The
37 scope of teaching may embrace subjects which are within the legitimate scope of the allied
38 health profession and which are designed to prepare students to engage in the practice of the
39 profession within the limits prescribed by law. (4) It is inappropriate to substitute the services

- 1 of an allied health professional for those of a physician when the allied health professional is
2 not appropriately trained and duly licensed to provide the medical services being requested. (I,
3 V, VII) Issued December 1997.
- 4 • H-35.985 – AMA Role in Allied Health Education and Accreditation. H-35.985 calls on the
5 AMA to “. . . reaffirm its commitment to promoting quality in allied health education. (CME
6 Rep. E, I-86; Amended by Sunset Report, I-96).
 - 7 • H-35.996 – Status and Utilization of New or Expanding Health Professionals in Hospitals. H-
8 35.996 provides “(1) The services of certain new health professionals, as well as those
9 professionals assuming an expanded medical service role, may be made available for patient
10 care within the limits of their skills and the scope of their authorized practice. The occupations
11 concerned are those whose patient care activities involve medical diagnosis and treatment to
12 such an extent that they meet the three criteria specified below: (a) As authorized by the
13 medical staff, they function in a newly expanded medical support role to the physician in the
14 provision of patient care. (b) They participate in the management of patients under the direct
15 supervision or direction of a member of the medical staff who is responsible for the patient's
16 care. (c) They make entries on patients' records, including progress notes, only to the extent
17 established by the medical staff. Thus this statement covers regulation of such categories as the
18 new physician-support occupations generically termed physician's assistants, and those allied
19 health professionals and nurses functioning in an expanded medical support role. It is not
20 intended to cover regulation of nurses and allied health professionals performing their regular
21 and customary roles, nor nurse practitioners functioning within the legal definition of nursing.
22 (2) The hospital governing authority should depend primarily on the medical staff to
23 recommend the extent of functions which may be delegated to, and services which may be
24 provided by, members of these emerging or expanding health professions. To carry out this
25 obligation, the following procedures should be established in medical staff bylaws: (a)
26 Application for use of such professionals by medical staff members must be processed through
27 the credentials committee or other medical staff channels in the same manner as applications
28 for medical staff membership and privileges. (b) The functions delegated to and the services
29 provided by such personnel should be considered and specified by the medical staff in each
30 instance, and should be based upon the individual's professional training, experience, and
31 demonstrated competency, and upon the physician's capability and competence to supervise
32 such an assistant. (c) In those cases involving use by the physician of established health
33 professionals functioning in an expanded medical support role, the organized medical staff
34 should work closely with members of the appropriate discipline now employed in an
35 administrative capacity by the hospital (for example, the director of nursing services) in
36 delineating such functions. (BOT Rep. G, A-73; Reaffirmed: CLRPD Rep. C, A-89;
37 Reaffirmed: Sunset Report, A-00).
 - 38 • H-160.949 – Practicing Medicine by Non-Physicians. H-160.949 states that “[o]ur AMA: (1)
39 urges all people, including physicians and patients, to consider the consequences of any health
40 care plan that places any patient care at risk by substitution of a non-physician in the diagnosis,
41 treatment, education, direction and medical procedures where clear-cut documentation of
42 assured quality has not been carried out, and where such alters the traditional pattern of
43 practice in which the physician directs and supervises the care given; (2) continues to work
44 with constituent societies to educate the public regarding the differences in the scopes of
45 practice and education of physicians and non-physician health care workers; (3) continues to
46 actively oppose legislation allowing non-physician groups to engage in the practice of
47 medicine without physician (MD, DO) training or appropriate physician (MD, DO)
48 supervision; (4) continues to encourage state medical societies to oppose state legislation
49 allowing non-physician groups to engage in the practice of medicine without physician (MD,

1 DO) training or appropriate physician (MD, DO) supervision; and (5) through legislative and
2 regulatory efforts, vigorously support and advocate for the requirement of appropriate
3 physician supervision of non-physician clinical staff in all areas of medicine. (Res. 317, I-94;
4 Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res.
5 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00).”

- 6 • H-275.976 – Boundaries of Practice for Health Professionals. H-275.976 provides “(1) The
7 health professional who coordinates an individual’s health care has health professional who
8 coordinates an individual's health care has an ethical responsibility to ensure that the services
9 required by an individual patient are provided by a professional whose basic competence and
10 current performance are suited to render those services safely and effectively. In addition,
11 patients also have a responsibility for maintaining coordination and continuity of their own
12 health care. (2) As a supplement to strengthen state licensure of health professionals, standard-
13 setting and self-regulatory competency assurance programs should be conducted by health
14 professions associations, certifying and accrediting agencies, and health care facilities. (BOT
15 Rep. NN, A-87; Reaffirmed: Sunset Report, I-97).

16 17 **SCOPE OF PRACTICE PARTNERSHIP**

18 19 History

20
21 The Scope of Practice Partnership (SOPP) was created by a coalition comprised of the AMA, six
22 national medical specialty societies (American Academy of Ophthalmology, American Academy
23 of Orthopaedic Surgeons, American Academy of Otolaryngology – Head and Neck Surgery,
24 American Psychiatric Association, American Society of Anesthesiologists, and American Society
25 of Plastic Surgeons) and six state medical associations (California Medical Association, Colorado
26 Medical Society, Maine Medical Association, Massachusetts Medical Society, New Mexico
27 Medical Society, and Texas Medical Association). Members of this coalition (referred to as the
28 “SOPP Steering Committee”) agreed that it was necessary to concentrate the resources of
29 organized medicine to oppose scope of practice expansions by allied health professionals that
30 threaten the health and safety of the public. The SOPP Steering Committee agreed that this would
31 best be accomplished through a wide-range of efforts, including a combination of legislative,
32 regulatory and judicial advocacy, as well as programs of information, research and education.
33 Moreover, the SOPP Steering Committee was committed to creating a true partnership that
34 operated by consensus and functioned in a cooperative and coordinated manner.

35
36 The SOPP Steering Committee has met either in person or via conference call quarterly for the last
37 two years. During this time, it developed various core documents that serve as the foundation for
38 the SOPP. Three main principles that the SOPP Steering Committee agreed to are as follows:

- 39
40 • Oversight: A Steering Committee currently composed of six state medical association
41 representatives, six national medical specialty society representatives, and one AMA
42 representative will oversee the activity of the SOPP.
- 43
44 • Membership: Input from all state medical associations and national medical specialty societies
45 will be vital to the viability of the SOPP. The SOPP and its Steering Committee will be open
46 for participation by any state medical association and/or national medical specialty society
47 represented in the AMA HOD. The greater the number of members, the greater the resources
48 (both financial and in-kind) the SOPP will have to advance its advocacy efforts.

- 1 • Funding: SOPP project funding will be derived solely from the annual dues collected from all
2 medical societies participating in the SOPP. In other words, the amount of dues raised in any
3 given year will dictate the SOPP's level of involvement in scope of practice initiatives.
4
- 5 • Consensus: The SOPP Steering Committee has identified consensus decision-making as one of
6 its fundamental operating principles. This is a process that attempts to recognize and account
7 for the differing, legitimate interests of all of its members and maximizes opportunities to
8 resolve differences and reach agreement.
9

10 The AMA also sought a detailed and exhaustive legal review of the SOPP by its Office of General
11 Counsel (OGC). This was done in order to ensure that the creation of the SOPP was not in
12 violation of any existing antitrust, truth in advertising, election, or lobbying laws. Understandably,
13 this was a very extensive review. Ultimately, the AMA OGC approved of the underlying
14 principles governing the SOPP. Furthermore, per AMA OGC's insistence, all members of the
15 SOPP will be required to sign a Statement of Legal Compliance, which ensures that all
16 participating medical societies are committed to conducting all activities of the SOPP in
17 compliance with all applicable federal, state, and local laws. The Statement of Legal Compliance
18 reiterates that at all times, the SOPP will have as its goal the protection of the health and safety of
19 patients whose well-being may be threatened by health care practitioners who lack education,
20 training or experience to perform procedures for which they seek licensure.
21

22 From its inception, the SOPP Steering Committee has envisioned that the SOPP's involvement in
23 scope of practice "campaigns" would be multi-dimensional. The members of the SOPP Steering
24 Committee had the foresight to see that the SOPP would become involved not only in the
25 individual state legislative, regulatory, and judicial advocacy, but also in programs of information,
26 research and education. From the very start, the SOPP Steering Committee's discussions focused
27 on two "top priority" research projects. Both studies would be extensive and therefore, benefited
28 from the formation of the SOPP and the concentration of the Federation's resources. The first of
29 these studies would focus on discrediting access to care arguments repeatedly made by various
30 allied health professionals when seeking to expand their respective scope of practice, particularly in
31 rural states. The second study, and arguably the more extensive of the two, would concentrate on
32 completing educational/training/licensure comparisons of specific allied health professions and the
33 medical profession. Obviously the second study aligns perfectly with Resolution 814.
34

35 Official Roll-Out of SOPP

36

37 The SOPP was officially rolled out at the AMA Advocacy Resource Center's (ARC) 2006 State
38 Legislative Strategy Conference in January. Up to that point in time, the SOPP had been favorably
39 received by the Federation and was enthusiastically embraced by the attendees of the conference.
40 During this meeting, AMA staff sought input from the conference attendees regarding a proposed
41 draft 2006 SOPP Work Plan. This work plan provided a series of action steps which
42 operationalized the SOPP. One of these steps included the need for the SOPP Steering Committee
43 to identify SOPP projects for 2006. The work plan included the following ideas for possible SOPP
44 projects: (1) education/training/ certification/licensure/ethical standards/disciplinary
45 processes/peer review/etc. comparisons between the medical profession and specific allied health
46 professions (per Resolution 814); (2) discrediting access to care arguments made by various allied
47 health professionals, particularly in rural areas of a state; (3) creating maps that identify the
48 locations of physicians, by specialty, to be used to counter claims that physicians do not exist in
49 certain areas of a given state; and (4) same as (1) but for the medical profession and specific

1 complementary/alternative medicine professions. It is notable that the draft SOPP Work Plan
2 clearly identifies (1) as its “top priority” for SOPP projects in 2006.

3

4 Next Steps

5

6 Since the 2006 State Legislative Strategy Conference, ARC staff has sent letters to the executive
7 directors of all state medical associations and national medical specialty societies recognized by the
8 AMA HOD. These letters included, as attachments, the SOPP’s core documents, as well as the
9 Statement of Legal Compliance for all medical societies to sign and an invoice for annual dues for
10 all national medical specialty societies and the AMA to process. ARC staff is currently fielding
11 any questions associated with these memos and processing all dues that are sent by the Federation.

12

13 Furthermore, the SOPP Steering Committee considered the draft SOPP Work Plan at its face-to-
14 face meeting on March 13, 2006. The priority for this meeting was determining the amount of
15 annual dues raised and based on that, identifying SOPP 2006 projects. Shortly after the SOPP
16 Steering Committee meeting, the ARC team added a new full-time legislative attorney who was
17 hired to focus their attention on scope of practice issues. This is an exciting addition to the ARC
18 team and signifies the AMA’s continued commitment to addressing scope of practice issues in an
19 effective, collaborative and cooperative manner with its Federation partners.

20

21 **CONCLUSION**

22

23 The AMA will continue to play an active role as a convener and consensus builder between state
24 medical associations and national medical specialty societies with respect to scope of practice
25 issues. In this role, the AMA will continue to support the SOPP and be an active member of its
26 Steering Committee. Moreover, ARC staff will continue to monitor and track scope of practice
27 developments at the state level, expand its Scope of Practice Campaign when deemed necessary,
28 and work with affected state medical associations and national medical specialty societies, at their
29 request, to oppose allied health professions that seek to expand their scope of practice in a manner
30 that threatens the health and safety of the public. The Federation has been energized by the
31 development of the SOPP and the AMA will continue its work in bringing organized medicine
32 together to fight these scope of practice battles.