MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 2-13

INTRODUCED BY: Baltimore County Medical Association

SUBJECT: Development of Models/Guidelines for Medical Teams

Whereas, as a result of the passage of the Patient Protection and Affordable Care Act there will be
a significant expansion of the population of patients served by a Medical Home; and

Whereas, the Medical Home model implies long term personal care and oversight of patients in a
community setting for ambulatory, urgent and acute care, preventive care, the monitoring of
chronic conditions as well as being a resource for appropriate referrals to specialists and hospitals
for care not provided in the Medical Home; thus avoiding the episodic, but significant expense of
crisis care due to of neglect of appropriate monitoring and preventive care that previously resulted
in increased morbidity and mortality; and

Whereas, even with the increase in medical student class size, it is unlikely that there will be
enough physicians to individually provide all the care that will be needed for at least the next ten
year transition period and possibly longer; and

Whereas, one proposed solution to expanding the medical caregiver population immediately is to
use non-physician providers acting within medical teams to extend physician’s medical care under
physician crafted guidelines; and

Whereas, our AMA at IM-12 adopted as amended the “Council on Medical Education – Council
on Medical Service Joint Report: The Structure and Function of Interprofessional Health Care
Teams”; and

Whereas, this document offered a definition of “physician led” health care teams and the principles
they should establish, including: (a) focus on patient and family-centered care, (b) clarity about the
teams mission, vision and values, (c) requirements for teams to provide direction and collaborate
on patient care, and (d) holding teams accountable for clinical care, quality improvement,
efficiency of care and continuing education, as well as, asking that the AMA continue studying
payment mechanisms, liability, credentialing of different team members and ethical issues that
may arise; and

Whereas, although our AMA action provided important broad principles, many relevant specifics
were not addressed, for example: what does “physician-led” mean: Does it mean the physician’s
authority is absolute? Are there circumstances in which it can be overridden? If there are, what are
they, and is it necessary that there be written protocols for the team on this? Is a physician
forbidden to practice in a non-physician-led team? What does that mean? Can physician leadership
exist without physicians having final authority about medical decisions? If a physician bears the
major responsibility for liability on a physician-led team, who bears it on a non-physician led
team? Should the liability be that of the physician leader or of every member of the team
individually or of the team as a whole?; and

Whereas, there are available models in the airline industry (CRM = Crew Resource Management
and PACE = Probing for a better understanding; Alerting captain of anomalies; Challenging
suitability of present strategy; Emergency warning of critical and immediate dangers) and the
nuclear power industry etc. that address safety and authority in those industries that might be
adapted for use within medicine to help to answer some of the team questions posed above;
therefore be it

Resolved, that MedChi ask our AMA to study and report back on important unanswered questions
about medical teams and leadership thereof in order to benefit the physician community including
academic training programs; and be it further

Resolved, that Med Chi ask our AMA to propose acceptable models that value the expertise of the
physician and could be used by such teams including specific issues such as safety and authority
within the teams, any role of physicians in a non physician-led team, and the ethical and legal
issues of the team model.

As adopted by the House of Delegates at its April 27, 2013 meeting.