AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: F
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Introduced by: RFS Governing Council

Prepared by: RFS Committee on Legislation and Advocacy

Subject: Physician Autonomy

Referred to: Reference Committee

INTRODUCTION

The 2018 Interim and 2019 Annual meeting referred several resolutions surrounding the overarching issue of Physician Autonomy. Included in these resolutions were CC&B Report 5 (I-18), "Protection of Physician Freedom of Speech", introduced by the American Academy of Pain Medicine; CC&B Report 6 (I-18), "Physicians' Freedom of Speech", introduced by the Minority Affairs Section; and 701 (A-19), "Employed Physicians Bill of Rights", introduced by Illinois. These resolutions were referred for further study. The AMA-RFS Governing Council assigned these items to the Committee on Legislation and Advocacy for report back at the 2020 AMA-RFS Annual Meeting.

This report takes elements from each of the referred resolutions and discusses relevant information regarding the overarching issue of physician autonomy. This report discusses the effects of scope of practice expansion, health system consolidation, the replacement of physicians in leadership positions, limitations on physicians' freedom of speech, the formation of a physician bill of rights, and unionization on physician autonomy. This report makes several recommendations.

DISCUSSION

Physician Employment and Scope of Practice

Expansion of non-physicians' scope of practice directly impacts physician autonomy. The AMA has strong policy protecting physicians' scope of practice. The AMA actively "defends the practice of medicine against scope of practice expansions that threaten patient safety". It is noted that "for over 30 years, the AMA's state and federal advocacy efforts have safeguarded the practice of medicine by opposing nurse practitioner (NP) and other non-physician professional attempts to inappropriately expand their scope of practice".[1] Through countless tools, including legislative victories, advocacy, creation of the *Health Workforce Mapper*, creation of the *Truth in Advertising* campaign, and engagement with the Federal Trade Commission, the AMA has provided the greatest defense against attacks on physician autonomy and scope of practice. In 2019, the AMA helped to defeat more than 50 scope-of-practice bills across the country.

This report serves as only a cursory review of previous AMA policy and advocacy efforts on scope of practice. However, this report will emphasize scope of practice issues that specifically affect residents and fellows.

There has been increased attention on post-graduate training programs for Physician Assistants (PAs) and Nurse Practitioners (NPs). While performing post-graduate training is not mandatory for NPs/PAs, optional post-graduate training is available for NPs and PAs in multiple specialties including primary care, pediatrics, dermatology, cardiology, oncology, surgery, emergency, gastroenterology and psychiatry, among others.[2] These programs often exist in academic health centers, where midlevel providers train among resident physicians. However, because these midlevel training programs exist outside the ACGME, with no alternate overarching governing body, hourly working commitments and responsibilities vary highly by program. Additionally, because these programs are funded outside of the traditional Medicare GME funding that supports most physician residency training programs, midlevel trainees are not always reimbursed on a PGY salary level. Because of this, some programs reimburse midlevel providers in training at a higher rate than resident physicians, sometimes up to 80% of a practicing midlevels salary.[3] In certain circumstances, this can lead to first year midlevel graduates earning more than resident physicians who have already completed multiple years of training.

A recent US Government Accountability Office report to Congressional Committees from December 2019 outlined potentials for expanding Medicare GME funding to NPs and PAs.[4] Currently, the majority of post-graduate physician training is financed through CMS' Medicare GME funding program. In contrast, post-graduate training programs for NPs and PAs are funded through a variety of sources including HRSA grants, as well as the Graduate Nurse Education Demonstration, a CMS program established through the ACA. However, this GAO report discussed the possibility of expanding GME funding for midlevel providers in an attempt to both stabilize and increase funding for these positions. Expanding GME funding for midlevel postgraduate training raises critical issues for physician trainees. CMS reimburses hospitals based on the number of physician residency positions. Because NPs and PAs are not required to complete post-graduate training in order to practice, this reimbursement structure would have to be evaluated if funding were to be utilized for NPs and PAs. Additionally, expanding the Medicare GME funding for NPs and PAs has the potential to decrease the amount of already-limited funding available for physicians in training.

Impact of Health System Conglomeration and Consolidation

Healthcare consolidation and conglomeration can have a profound effect on physician autonomy. There has been a tremendous amount of consolidation in the healthcare industry over the last 20 years. Data from the American Hospital Association revealed that there were 1,412 hospital mergers from 1998 to 2015, with 561 occurring from 2010 to 2015.[5] A trade publication documents an additional 115 hospital mergers in 2017 and 102 in 2016 and 2017.[6] Additionally, there have been a very large number of acquisitions of physician practices by hospitals. In 2006, 28 percent of primary physicians were employed by hospitals. By 2016, that number had risen to 44 percent. The American Medical Association reports that 33 percent of all physicians were employed by hospitals in 2016, and less than half own their own practice.[6] Additionally, an increased concentration in primary care physician markets is associated with practices being owned by hospitals.[5]

A side effect of healthcare consolidation is an increase in hierarchical structure and healthcare administrators. Healthcare administrators are most often not physicians. The increased prevalence of these administrators has concomitantly led to a loss of physicians in leadership positions.[7] Growth of administration in conjunction with the loss of physician leadership inevitably leads to the loss of physician autonomy in clinical decision-making.[8] Physicians are subjected to rules and regulations enacted by large healthcare system management in order to increase profit. Administrators are empowered to dictate physician productivity in ways such as regulating the number of patients that physicians are expected to see and creating reimbursement that is contingent on factors that are caused by a multitude of factors such as complication rates and patient satisfaction. Additionally, despite the large numbers of healthcare administrators, an increasing amount of administrative burden is being shunted to physicians in the forms of documentation, billing, prior authorization and insurance restrictions, among others, the majority of which requires increased time without an associated increase in compensation.

Because the consolidation of healthcare systems is largely completed in order to maximize profits, some systems have attempted to replace physicians with midlevel providers in order to maximize cost savings and profits. Recently, one hospital system in Illinois unexpectedly terminated 15 urgent care physicians and replaced them with midlevel providers in an effort to cut cost spending.[9] While this decision was later revoked, mostly due to public outcry and media attention, this serves as one example of many in which healthcare system conglomeration threatens to undermine physician autonomy and even replace physicians completely.

Physicians' Freedom of Speech

Limitations on physicians' freedom of speech have a profound impact on physician autonomy. These limitations traditionally have come from governmental regulations, though internal limitations from healthcare systems may also limit physicians' speech in terms of regulating advocacy and expressions of personal beliefs.

Recent legislation demonstrates the myriad ways that state and federal governments can restrict physicians' speech. In 2019, North Dakota passed two laws restricting physician speech pertaining to pregnancy termination.[10] This legislation required that physicians must inform patients that it "may be possible to reverse the procedure", as well as that abortion terminates "the life of a whole, separate, unique, living human being". The Trump administration's changes to Title X also capitated physician autonomy and freedom of speech.[11] Essentially, these changes created a "gag rule", so that any provider or organization that provided abortion services, or even referred patients to abortion services, were no longer eligible for Title X funding, a federal health program that funds STI treatment, cancer screening and contraception to underserved populations.

Yet another example of attacks on physician free speech is the "gag rule" regarding firearm safety. The term refers to the "Firearm Owners' Privacy Act," a law passed in Florida in 2011, which prohibited doctors from "making written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient."[12] This law, along with similar laws that have been passed in Minnesota, Missouri and Montana, explicitly prohibit the conversations that a physician may hold with his or her patient. While this law was ultimately overturned, it highlights the continued

assault on physician autonomy and governmental regulations of the physician-patient relationship.

Ironically, while physicians' autonomy is limited by legislation, other providers, or lay people claiming to be providers, are not subject to such regulations. Because physicians must adhere to governmental regulations of our profession, we often have our hands tied in ways that others do not. For example, an existing California law known as the Freedom, Accountability, Comprehensive Care, and Transparency Act (FACT act), which mandate that "Crisis Pregnancy Centers", namely faith-based counseling centers that focused on abortion and pregnancy, required licensed centers to post visible notices that other options for pregnancy, including abortion, are available from state-sponsored clinics. It also mandated that unlicensed centers post notice of their unlicensed status and inability to perform "all pregnancy-related procedures."[13] However, in 2018, this California law was overturned by the Supreme Court, which ruled that the law limited the First Amendment rights of these centers and workers. The implications of the ruling were in essence that while there is precedent for regulating and even directly dictating physician speech when counseling a patient, there is no such corresponding right to curtail the speech of unlicensed medical professionals while providing their opinions on healthcare to these same patients.

These assaults on physicians' freedom of speech are a direct affront to our autonomy. By limiting the types of questions that we may discuss with our patients, as well as the types of medical procedures that we may discuss is an assault on the physician patient relationship. Additionally, lay people are not held to the same standard that we as physicians are, they are entitled more freedoms in projecting unfounded claims not backed by science or fact. The AMA continues to fight to protect physicians' freedom of speech through countless legal battles, advocacy efforts and campaigns in order to preserve not only our autonomy but also to protect public health, scientific evidence, and protect our patients.

Physician Unionization

Many professions have developed labor unions over the past several decades to advocate and collectively bargain on behalf of their members. The idea of physician unionization has long been considered a way to collectively fight for physician autonomy but has never been adopted on a wide scale. In 1972, Dr. Sanford Marcus called upon the AMA to organize a physician union but was met with a firm rejection of the idea.[14] He struck out on his own and later that year formed the Union of American Physicians and Dentists, which now works in affiliation with the AFL-CIO (American Federation of Labor and Congress of Industrial Organizations) to represent physicians in California and Washington. The rest of the 1970s saw the birth of several small physician unions in states like Florida, New York, Texas, and Nevada. In 1974, the National Labor Relations Board officially announced that non-supervisory physicians were eligible to organize labor unions.[15,16] Since that time, physician unions have successfully bargained on behalf of employed physicians to improve work hours, compensation, clinic schedules, and fringe benefits. However, a cohesive, national union has never emerged to collectively bargain on behalf of employed physicians. In terms of physicians in training, there is one large organization that has grown since its founding in 1957, the Committee of Interns & Residents. This housestaff union currently represents about 17,000 residents and fellows in 7 states across the US.[17] This union has successfully negotiated work-hour limits,

maternity leave, due process, wellness initiatives, patient protection funds, housing stipends, increased pay, and other benefits for individual training programs. The history of small-scale physician unions suggests that larger scale efforts may be even more effective to support the rights of physicians.

Physician Bill of Rights

One of the ways that formal organizations can support physician autonomy is through the development of a Bill of Rights. The first attempt to develop a Physician Bill of Rights was in 1999 when HR 3300 was introduced in Congress.[18] It was focused on targeting medical fraud but ultimately was never passed. Another bill of rights was proposed in 2012 and it focused on improving patient compliance and supporting the patient-physician relationship, however this bill also never passed into law.[19]
Our AMA-RFS developed a resident and fellow bill of rights that is available for programs to use across the country.[20] Others have proposed versions of a physician bill of rights including residents at Yale University and Dr. Michele Parker to focus on improving physician autonomy and decreasing burnout.[21,22]

The common principles to protect include fair compensation and benefits, safe duty hour regulations, appropriate supervision, and standardized accountability processes. These documents have been developed in an attempt to fill a gap in resident/fellow advocacy that has led to inappropriate working conditions at many programs. For example, it is well studied that duty hour violations are commonplace and consistently underreported across training programs in the US.[23,24] The Accreditation Council for Graduate Medical Education (ACGME) supports residents and fellows by scrutinizing programs and withholding accreditation when program requirements are violated, however direct representation of trainees in the ACGME is limited and distant.[25] The widespread adoption of a resident and fellow bill of rights would be one method of improving individualized advocacy at training programs to support trainee autonomy, prevent burnout, and improve quality of care.

Existing AMA Policy

The AMA has extensive policies supporting the many different aspects of protecting physician autonomy. The AMA supports expansion and stability of GME positions (Policy D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education”; Policy H-310.917, “Securing Funding for Graduate Medical Education”). AMA also supports the residents and fellows’ rights to adequate compensation and benefits that provide for well-being and health (Policy H.310-912, “Residents and Fellows’ Bill of Rights”). Policy also exists to protect the titles of “Doctor”, “Resident” and “Residency” and supports state legislations making it a felony to misrepresent oneself (H-275.925, “Protection of the Titles “Doctor,” “Resident” and “Residency”). AMA also supports preserving physician clinical autonomy (Policy H-235.974, “Autonomy of the Hospital Medical Staff”; Policy D-225.977, “Physician Independence and Self-Governance”).

AMA has policy that also supports “a physician’s First Amendment right to express opinions relating to medical issues (H-435.940, “Protection of Physician Freedom of Speech”). With regards to scope of practice, AMA has many policies to support data collection and produce advocacy tools to better understand its impact, as well as “oppose

state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation (Policy D-160.995, “Physician and Nonphysician Licensure and Scope of Practice). AMA also supports physicians' right to advocate for change in law and policy as long as it is not disruptive to patient care (Policy 1.2.10, “Political Actions by Physicians”). While policy exists stating that AMA does not support using collective actions, such as strikes, as a bargaining tool (Policy 1.2.10, “Political Actions by Physicians”), more recent 2019 AMA policy supports studying the “risks and benefits of collecting bargaining for physicians and physicians-in-training in today’s healthcare environment” (Policy D-383.977, “Investigation into Residents, Fellows and Physician Unions”).

RECOMMENDATIONS

Based on the report and recommendations prepared by the AMA-RFS Council on Legislation and Advocacy, your AMA-RFS Governing Council recommends the following:

1) That our AMA-RFS support equivalent or better reimbursement between physicians in training and midlevel providers at equal postgraduate training levels, and that these payments account for the level of complexity of care provided, workload, and number of hours worked.

2) That our AMA-RFS support the restriction of the terms “residency” and “fellowship” to refer specifically to physicians-in-training.

3) That our AMA-RFS oppose: a) caps to GME funding for physicians-in-training; and b) diversion of GME funding for midlevel training positions.

4) That our AMA-RFS support reducing administrative burden for physicians-in-training.

5) That our AMA-RFS reaffirm position statement 170.011R “Investigation into Residents, Fellows, and Physician Unions.”

6) That our AMA reaffirm policy H-160.912.

7) That our AMA reaffirm policy D-383.996.

8) That our AMA amend the *Residents and Fellows' Bill of Rights* (policy H-310.912) by addition to read as follows:
   8. Our AMA will distribute and promote the *Residents and Fellows’ Bill of Rights* online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

9) That our AMA study the curriculum and accreditation requirements for midlevel provider programs and make recommendations for scope of practice legislation with report back by A-22.

REFERENCES

1. American Medical Association. “AMA successfully fights scope of practice expansions that threaten patient safety”. Available from: https://www.ama-assn.org/practice-management/payment-delivery-models/ama-successfully-fights-scope-practice-expansions
2. NP Schools, “Nurse Practitioner Fellowship and Residency Programs”. Available from: https://www.nursepractitionerschools.com/blog/np-fellowship-residency-programs/
3. Norwick, RM. Family Nurse Practitioner Residency for Recruiting and Retention. The Journal for Nurse Practitioners, May 2016, 12 (5): e231-e233.
4. https://www.gao.gov/assets/710/703372.pdf
5. Fulton, B. D. (2017). Health care market concentration trends in the United States: Evidence and policy responses. Health Affairs, 36(9): 1530–1538.
6. Kaufman Hall (2018). 2017 in review: The year M&A shook the healthcare landscape. Skokie, IL: Kaufman Hall and Associates, LLC, https://www.kaufmanhall.com/resources/2017- review-year-ma-shook-healthcare-landscape.
7. Woolhandler S, Campbell T, Himmelstein D. Costs of Health Care Administration in the United States and Canada. N Engl J of Med 2003; 349: 768-775.
8. American Medical Association Report 7 of the Council on Medical Service (A-19): Hospital Consolidation. Available from: https://www.ama-assn.org/system/files/2019-07/a19-cms-report-7.pdf
9. Rappleye, Emily. Becker’s Hospital Review. Edward-Elmhurt to replace physicians with midlevel providers at immediate care sites. Dec 2, 2019. Available from: https://www.beckershospitalreview.com/hospital-physician-relationships/edward-elmhurst-to-replace-physicians-with-midlevel-providers-at-immediate-care-sites.html
10. North Dakota Abortion Law 1: HOUSE BILL NO. 1336: https://www.legis.nd.gov/assembly/66-2019/documents/19-0517-03000.pdf
11. Sarah McCammon. Title X: Trump Administration Proposes Changes To Federal Family Planning : NPR [Internet]. NPR News. Available from: https://www.npr.org/2019/02/22/690544297/trump-administration-proposes-sweeping-changes-to-federal-family-planning-progra
12. McCourt, A and Vernick, JS. Law, Ethics and Conversations between Physicians and Patients about Firearms in the Home. AMA J of Ethics. 2018; 20(1):69-76.
13. Watterhahn, M and Boumil, M. US Supreme Court Strikes Down California FACT Act. Health Affairs Blog. June 29, 2018. Available from: https://www.healthaffairs.org/do/10.1377/hblog20180628.429780/full/
14. Union of American Physicians and Dentists (https://www.uapd.com/all-doctors-need-a-union/)
15. National Labor Relations Act information (https://www.nlrb.gov/rights-we-protect/rights/employee-rights)
16. Perspective from the United Steelworkers (https://m.usw.org/news/media-center/articles/2019/usw-healthcare-staff-members-pen-articles-in-physicians-journal-about-unionizing)
17. Committee of Interns and Residents (https://www.cirseiu.org/our-history-2/)
18. Bill of Rights, HR3300 https://www.congress.gov/bill/106th-congress/house-bill/3300
19. Doctor’s Bill of Rights. https://www.prweb.com/releases/2012/3/prweb9339072.htm
20. AMA-RFS Residents’ and Fellows’ Bill of Rights. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/rfs/rfs-bill-rights_0.pdf
21. The resident and Fellow Bill of Rights. https://www.wnpr.org/sites/wnpr/files/201910/copy_of_the_resident_and_fellow_bill_of_rights_with_footnotes.pdf
22. Parker, M. The Physician’s Bill of Rights. https://www.kevinmd.com/blog/2017/02/physicians-bill-rights.html
23. Dziorny, AC, Orenstein, EW, Lindell, RB, Hames, NA, Washington, N, and Desai, B. Pediatric trainees systematically under-report duty hour violations compared to electronic health record defined shifts. PLOS ONE, 2019 Dec; 14(12): e0226493.

24. Drolet, BC, Schwede, M, Bishop, KD, and Fischer, SA. Compliance and Falsification of Duty Hours: Reports From Residents and Program Directors. J Grad Med Educ, 2013 Sept; 5(3): 368-373.
25. Accreditation Council for Graduate Medical Education https://www.acgme.org/Residents-and-Fellows/Welcome