

SUBJECT TO RESOLUTION COMMITTEE REVIEW

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 615
(N-21)

Introduced by: Oklahoma, Alabama, District of Columbia, Georgia, Mississippi, New Jersey,
North Carolina, South Carolina, Tennessee

Subject: Employed Physicians

Referred to: Reference Committee F

Whereas, The percentage of practicing US physicians who are employed is now heading towards 75% and may go higher with early retirement of older “private practice” physicians; and

Whereas, The Southeastern Delegation to AMA (SED) supports both pluralistic health insurer or payor mix and pluralistic physician practice styles and settings; and

Whereas, Many physicians are losing influence in the health care system under some employment models; and

Whereas, Physicians’ employment by a hospital completely changes any past relationships to the hospital administration, whether the hospital has an active Organized Medical Staff or not; and

Whereas, Many physicians are naïve about contract negotiations and terms and can’t afford legal or accounting review; and

Whereas, Many employed physicians are naïve about contract renewals and supporting employer accounting systems and can’t afford their own forensic accountants; and

Whereas, The AMA is currently limited in the scope of its potential work with employed physicians and hospital or corporate medical staffs; and

Whereas, The SED believes that continued membership growth of AMA will depend on the AMA adapted to the needs of employed physicians; and

Whereas, The process of providing additional support for employed physicians may take several years; may involve input from the AMA Councils; may require input from internal AMA or contract legal counsel; may require input and study by the AMA Board and AMA CEO; and

Whereas, The SED believes our AMA should start “the process” for change now; therefore be it

RESOLVED, That our American Medical Association dedicate full-time staff to the Employed Physician to aggressively address relevant AMA Policy pertaining to the Employed Physician (Directive to Take Action); and be it further

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1 RESOLVED, That our AMA study amending Policy G-615.105 to read as follows:

2
3 Employed Physicians and the AMA G-615.105

4 1. Our AMA will become the lead association for physicians who maintain
5 employment or contractual relationships with hospitals, health systems, and other
6 entities.

7 2. As a benefit of membership our AMA will provide assistance, such as information,
8 advice, and legal opinions, as appropriate, to employed physicians, physicians in
9 independent practice, and independent physician contractors in matters pertaining to
10 their relationships with hospitals, health systems, and other entities, including, but not
11 limited to, breach of contracts, contract negotiations and contract renewals, medical
12 staff bylaws, sham peer review, economic credentialing, and the denial of due
13 process.

14 3. Our AMA will also work through the Organized Medical Staff Section and other
15 sections and special groups as appropriate to represent and address the unique
16 needs of physicians who maintain employment or contractual relationships with
17 hospitals, health systems, and other entities. (Directive to Take Action); and be it
18 further

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20 RESOLVED, That the representation of the Organized Medical Staff Section (OMSS) in the
21 AMA House of Delegates be increased from the current one Delegate to many Delegates based
22 on AMA membership numbers of employed physicians using the mathematical model(s), to
23 calculate the numbers of the New OMSS Delegates, currently being used at AMA for the
24 Medical Student and Resident and Fellows Sections to calculate the numbers of Regional
25 Medical Students and the numbers of Regional Resident/Fellows in the AMA House of
26 Delegates. The AMA would develop a practical meaning of the phrase "Employed Physician"
27 for the purposes of AMA membership counting, but as an editorial comment, the SED suggests
28 starting with employed Non-Resident/Non-Fellow physicians who have no ownership interest
29 (or, say, less than 1% ownership each) in their employer organization (New HOD Policy); and
30 be it further

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32 RESOLVED, That the Organized Medical Staff Section have one designated member who is a
33 defined employed physician on all AMA Boards and Committees and Councils to match the
34 MSS, the RFS and the YPS. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Over 70% of physicians are now employed. This time of COVID has placed employed physicians at INCREASED vulnerability and disadvantage for practice and personal sustainability as employers and insurance companies have taken advantage of the difficult COVID health care system situation. THIS is our top Core Value, Physician and Physician practice sustainability. This will start a process that could take several years, BUT THIS IS THE TIME TO START with important NEW POLICY and a new AMA Office of the Employed Physicians. Obviously, AMA can make a positive impact and of course is really the only organization to undertake this important task.

HISTORY

H – 225.947 Physician Employment Trends
H – 225.950 Principles of Physician Employment
G – 615.105 Employed Physicians
D – 225.973 Employed Physicians Bill of Rights

References

The early Clinic histories from relevant Wikipedia articles.

Representation of Physicians in Emerging Delivery Systems; AMA Council on Long Range Planning and Development Report, 1994.

Rosemary Strevens. Health Care in the Early 1960's. Health Care Financing Review. Winter issue, 1996. Vol 1, #2.

Travis Singleton and Phillip Miller. The Physician Employment Trend: What you need to know. Fam Pract Manage 2015: August (4) 11-15.

The Physician Employment Movement. Career Letter, NEJM, July 23, 2014

Laura Dyrda. 70% Physicians now Employed by Hospitals or Corporations. July 1, 2021. VMG Health at info@vmghealth.com

The AMA OMSS web page: [Organized Medical Staff | American Medical Association \(ama-assn.org\)](https://www.ama-assn.org/organized-medical-staff)

EMPLOYMENT CONTRACTS

AMA Policy

H – 225.964 Hospital Employed/Contracted Physicians Reimbursement

H – 285.946 Fair Physician Contracts

References

Scott Backer, Gretchen Townsend, Holly Carnell, Melesa Freerks and McGuire Woods. Physician Compensation. In the Beckers Hospital Review, August 19, 2013

Kim Stanger. Physician Contract Check List. Proprietary to the Holland and Hurt Law Firm, from Shaw Publications

EMPLOYED PHYSICIAN SAFEGUARDS

AMA Policy

D – 215.990 AMA Assistance to Physician-Hospital/Healthcare System Relationships

H – 383.999 Physician Negotiations

H – 385.976 Physician Collective Bargaining

D – 225.977 Physician Independence

H – 235.999 All Physicians Employed by Hospitals Required to be on Staff

References

Brendan Murphy, AMA staff writer - So, you are an employed physician: what you need to know. June 2017.

<https://es4p.com> - Essentials for Physicians – Business Podcasts and Seminars

Travis Singleton and Phillip Miller. Physician Employment. August 2015 from the FPM Journal by the AAFP

Winn Halverhout, Husch Blackwell, Barbara Yosses. Compliance in Physician Employment. Proprietary to the Husch Blackwell Law Firm, published by the Health Care Compliance Association, 2010.

from the American College of Surgeons

https://www.facs.org/-/media/files/advocacy/regulatory/2018_employed_surgeons_primer.ashx

RELEVANT AMA POLICY

Employed Physicians and the AMA G-615.105

1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.

2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.

3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.

Citation: Res. 601, I-11; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

Physician Employment Trends and Principles H-225.947

1. Our AMA encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles: A. Physician clinical autonomy is preserved. B. Physicians are included and actively involved in integrated leadership opportunities. C. Physicians are encouraged and guaranteed the ability to organize

under a formal self-governance and management structure. D. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care. E. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care. F A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.

2. Our AMA encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession.

Citation: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

- a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
- b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
- c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
- d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
- (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
- (f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
- (g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
- (h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

- a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
- b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
- c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
- d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

- a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
- b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
- c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
- d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
- e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
- (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
 - i. The agreement is for the provision of services on an exclusive basis; and
 - ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
 - iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

- a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
- b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

Hospital Employed/Contracted Physicians Reimbursement H-225.964

AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians. Citation: (Sub. Res. 723, I-96; Reaffirmed: Res. 812, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: BOT Rep. 4, I-12)

All Physicians Employed by Hospitals Required to be on Staff H-235.999

The AMA believes that physicians having contractual or financial arrangements with hospitals should be members of the organized medical staff and responsible to it, should be subject to the bylaws of the medical staff, and should conduct their professional activities according to the standards, rules and regulations adopted by it.

Citation: BOT Rep. R, Rec. 3, A-77; Reaffirmed: I-81; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18

Fair Physician Contracts H-285.946

Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to:

- (1) disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies;
- (2) which proprietary "correct coding" CPT bundling program is employed;
- (3) grievance and appeal mechanisms;
- (4) conditions under which a contract can be terminated by a physician or health plan;
- (5) patient confidentiality protections;

- (6) policies on patient referrals and physician use of consultants;
 - (7) a current listing by name and specialty of the physicians participating in the plan; and
 - (8) a current listing by name of the ancillary service providers participating in the plan.
- Citation: Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08; Reaffirmed: CMS Rep. 01, A-18

Physician Negotiation H-383.999

1. All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs.
2. Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians authorized to organize labor organizations under the National Labor Relations Act.
3. Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers.

Citation: Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation A-08; Modified: BOT Rep. 09, A-18

Physician Collective Bargaining H-385.976

- Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians. (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature. (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively. (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients. (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

Citation: BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19

AMA Assistance for Members in Matters Pertaining to Physician-Hospital/Health System Relationships D-215.990

1. As a benefit of membership our AMA will provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.

2. Our AMA encourages the Federation of Medicine and its members to provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.

Citation: Res. 826, I-11; Reaffirmed: BOT Action in response to referred for decision Res. 816, I-16

Employed Physician Bill of Rights and Basic Practice Professional Standards D-225.973

Our AMA will advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

Citation: BOT Rep. 13, A-19

Physician Independence and Self-Governance D-225.977

Our AMA will: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.

Citation: (Res. 801, I-11; Modified: BOT Rep. 6, I-12)