

Keeping politics out of the exam room: Protecting the patient-physician relationship

The problem

Over the last few years, an alarming number of states introduced legislation that attempted to prescribe or proscribe the content of information exchanged between physicians and their patients. While this issue was most evident in bills that prohibit physicians from speaking to their patients about firearms and restrict access to abortion, this issue also arose when legislatures attempted to create content specific informed consent and prescribe mandatory end of life discussions. However, this issue is not about guns, abortion or “death panels.” This is about legislation that encroaches on the patient-physician relationship.

These legislative forays into the practice of medicine not only infringe on physicians’ First Amendment right to free speech, they potentially put physicians in an untenable position of risking disciplinary proceedings, criminal prosecution or abandoning ethical obligations to foster patient autonomy. More important than all of these considerations, however, is the real harm that may come to patients if these laws continue to interfere with their ability to be safe, and to have access to the most current medical information available.

Firearms

In 2011, Florida became the first state to enact a physician gag law. The “Firearm Owners’ Privacy Act” (the Act), essentially states that a physician cannot inquire about guns in the house unless the physician in good faith believes that the information is relevant to the patient’s medical care or safety or the safety of others. Patients can notify the Florida Board of Medicine if they feel “unnecessarily harassed” about guns during an examination by their physician. The Board of Medicine will be responsible to mete out disciplinary action at its discretion.

Soon after the Florida bill became law, a lawsuit was filed in the United States District Court for the Southern District of Florida, Miami Division, asking the court for injunctive relief to enjoin the state of Florida from enacting the Act. Three physicians and three state chapters of national medical specialty societies (Florida chapters of the American Academy of Pediatrics, American College of Physicians and American Academy of Family Physicians) sued Governor Rick Scott and other state officials to overturn the Act. In the lawsuit, the plaintiffs argued the Act imposed a restriction on the plaintiffs’ speech on the particular subject of firearms thereby violating the plaintiffs’ First and Fourteenth Amendment rights. The complaint argued that the Act abridged the freedom of plaintiffs to communicate with and to counsel their patients, using their best medical judgment in practicing preventive medicine to reduce the risks associated with firearms, failed to give the plaintiffs adequate notice of the conduct prohibited under the Act, and abridged the freedom of plaintiffs and their member patients to receive information on firearm safety as part of their preventive care. In addition, the plaintiffs argued the Act should be enjoined because it was vague, overbroad and ambiguous, and its penalties so harsh, that prudent practitioners would be forced to curtail or forgo altogether counseling patients with regard to firearms.

In June 2012, a federal judge struck down the Act, ruling that the law violated physicians' First Amendment right to free speech. In granting the permanent injunction, the Judge wrote that “the free flow of truthful, non-misleading information is critical within the doctor-patient relationship” and that the law “chills practitioners’ speech in a way that impairs the provision of medical care and may ultimately harm the patient.”

The state of Florida has subsequently appealed this ruling and the AMA, along with nine medical specialty societies filed an [Amicus Curiae Brief](#) in the Eleventh Circuit, in support of plaintiff physicians. Those medical societies include: the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Osteopathic Association, American Academy of Orthopaedic Surgeons, American College of Surgeons, American College of Preventive Medicine, American College of Obstetricians and Gynecologists, and American Psychiatric Association.

In the brief, the Amici assert the Act prevents physicians from communicating with their patients so as to provide medical care under the accepted standards of the medical profession. Not only do physicians lose the right to express themselves freely, but their patients are deprived of the full range of medical care and professionalism that they should and do expect from their physicians. Furthermore, the Amici contend the statutory restraint on record keeping contained in the Act, prevents physicians from taking a routine precaution that might enhance their defense against charges of medical malpractice.

Federal Court Ruling

On July 25, 2014, a panel of the United States Court of Appeals for the Eleventh Circuit, by a 2-1 decision, reversed the permanent injunction and upheld the Act against a facial attack based on the First Amendment. The court held that the Act “is a legitimate regulation of professional conduct that has only an incidental effect on physicians’ speech” and “simply codifies that good medical care does not require inquiry or record-keeping regarding firearms when unnecessary to a patient’s care.” Basically, the court concluded that when doctors ask questions of their patients, those questions constitute medical treatment and not speech, thus wholly outside First Amendment protections. Additionally, the court rejected the claims that the provisions in the Act were overbroad and unconstitutionally vague.

In a lengthy dissent, citing AMA policy 14 times, the court said the Act was a “gag order that prevents doctors from even asking the first question in a conversation about firearms.” The dissent elaborated, “the law significantly chills doctors from expressing their view and providing information to patients about one topic and topic only, firearms.” The dissent opined that doctors could be prohibited in the future from speaking to their patients about any particular topic, including the virtues of any school of medical thought, because such conversations are, strictly speaking, irrelevant to a patient’s care. More disturbingly, under the Majority’s reasoning, the dissent wrote, “any law burdening or eliminating speech will avoid First Amendment scrutiny so long as the law only applies within the confines of a one-on-one professional relationship. Then, according to the Majority, the speech is merely professional conduct and is entirely unprotected. States would be free to eliminate all irrelevant speech from a doctor’s office, all relevant speech from a doctor’s office, or just that speech which conflicts with the State’s preferred viewpoints.”

The AMA along with the other Amici petitioned the court for a rehearing by the full 11th Circuit Court of Appeals. In February 2016, the court granted plaintiffs’ petition for rehearing *en banc* and heard arguments on June 21, 2016. The injunction blocking enforcement of the law remains in effect until a decision is issued against Florida's physician gag law, meaning Florida physicians currently remain free to counsel their patients on gun safety when they feel it is appropriate.

State Legislation

In 2015, legislation similar to Florida’s law was introduced in 5 states (Indiana, North Carolina North Dakota, Ohio and Texas). To date no bill has been enacted. There is some speculation that the decision in

Wollschlaeger v. Governor of Florida may prompt state legislatures that have considered, but not enacted, similar legislation to move forward with bills restricting physicians' ability to question patients and their families about gun ownership or other private matters.

Women's Reproductive Health

Consistent with the increasingly conservative social agenda reflected in state legislatures last year, lawmakers around the country have introduced a torrent of measures aimed at restricting abortion. During the 2016 state legislative session, lawmakers in 19 states introduced legislation aimed at restricting access to abortion. Unlike previous years' bills, which tended to focus on abortion regulation by requiring mandatory ultrasound, pre-abortion counseling and waiting periods, the majority of 2016's bills are focused on restricting abortion after a specific point in gestation, under particular circumstances, or via certain methods. Several states also attempted to strip funding from family planning providers. According to the Guttmacher Institute, 46 new abortion restrictions have been enacted in 17 states this year.

Four states (AL, LA, MS and WV) enacted legislation to ban a particular method of abortion during the second trimester. Two states (SC and SD) banned abortion after 20 weeks and two states (IN and LA) passed legislation prohibiting abortion under certain circumstances. Indiana passed HB 1337 to ban abortions due to fetal genetic abnormalities, such as Down syndrome, or because of the race, sex or ancestry of a fetus, and to require that aborted fetuses be disposed of through burial or cremation. A Federal district court blocked implementation of Indiana's bill in June. Louisiana banned abortions due to fetal genetic abnormalities after 20 weeks.

Legislation was vetoed in Oklahoma that would have made performing an abortion a felony punishable by up to three years in prison. The vetoed bill in Oklahoma would have also required the state to revoke the medical license of any physician who performed an abortion except when necessary to protect the woman's life.

Supreme Court decision

In 2013, Texas passed a law (HB 2) requiring physicians who performed abortions to have admitting privileges at a nearby hospital and requiring abortion clinics to meet the same standards as ambulatory surgical centers (ASCs). Proponents of the law claimed the requirements were necessary to protect women's safety.

Five Texas clinics, three physicians, and their patients challenged the ASC requirement statewide and the admitting privileges requirement as applied to abortion clinics in two rural areas of the state, where women face the greatest obstacles in accessing abortion care. The trial court held the law constitutionally invalid as an unreasonable restraint on women's right to have an abortion, and it enjoined enforcement of the Texas law.

On October 2, 2014, the Fifth Circuit stayed enforcement of the trial court injunction, pending full resolution of the appeal. It found, with a minor exception, that the law would probably be sustained as a reasonable regulation of medical care. The plaintiffs appealed to the Supreme Court for review of the Fifth Circuit stay order. On October 14, 2014, the Supreme Court (with three justices dissenting) vacated the stay in part and let the stay order stand in part. The Supreme Court did not provide a rationale for its ruling.

The AMA and the American Congress of Obstetricians and Gynecologists filed an [amicus brief](#) in the Fifth Circuit to support the plaintiffs and oppose the Texas legislation. On June 9, 2015, the Fifth Circuit ruled, on the merits, that the Texas law for the most part did not unreasonably interfere with the right to an abortion and was therefore constitutional. In certain, relatively minor aspects, the Fifth Circuit reversed the trial court injunction against the law. On June 29, 2015, the Supreme Court (with four justices dissenting) stayed the Fifth Circuit mandate, pending the filing and disposition of a petition for certiorari.

The AMA, American College of Obstetricians and Gynecologists, American Academy of Family Physicians and American Osteopathic Association filed an [amicus brief](#) in the Supreme Court in support of the petition for certiorari. They also filed an amicus brief in the Supreme Court regarding the merits of the case. Amici argued that, “H.B. 2’s ASC requirement and privileges requirement are contrary to accepted medical practice and are not based on scientific evidence. They fail to enhance the quality or safety of abortion-related medical care and, in fact, impede women’s access to such care by imposing unjustified and medically unnecessary burdens on abortion providers.” The brief was cited three times in the Court’s decision.

In a 5-3 [decision](#) on June 27, 2016, the Supreme Court overturned the Texas law, finding that HB 2’s ASC requirement and privileges requirement, “vastly increase the obstacles confronting women seeking abortions in Texas without providing any benefit to women’s health capable of withstanding any meaningful scrutiny.” The Court held that “each [requirement] places a substantial obstacle in the path of women seeking a pre-viability abortion, each constitutes an undue burden on abortion access, and each violates the federal Constitution.”

The Supreme Court’s 5-to-3 decision in *Whole Woman’s Health v. Hellerstedt* has been called the most consequential abortion decision since *Planned Parenthood v. Casey* in 1992 and will likely have consequences for states with abortion restrictions that are as strict as Texas’s HB 2. According to the Guttmacher Institute, five states require physicians performing abortions to have active admitting privileges at area hospitals, and 22 states have ASC requirements. Although only the Texas law was before the Court, it is likely that these state laws will be overturned as well.

The solution

The AMA advocacy campaign entitled, “Keeping politics out of the exam room: Protecting the patient-physician relationship,” is a resource to assist states confronting legislation that encroaches on the sanctity of the patient physician relationship. This campaign can be adapted to a wide range of legislatively prescribed intrusions into the patient-physician relationship – e.g. legislation that attempts to dictate the content of physician’s conversations with their patients, content specific informed consent as well as codification of clinical procedures or standards. In addition, the ARC has collected numerous statements from state and specialty societies that have crafted skilled public statements on these issues which will assist other states with their advocacy.

Talking points

- The protection of the sanctity of the patient-physician relationship, including defending the freedom of communication between patients and their physicians, is a core priority for the AMA. The ability of physicians to have open, frank and confidential communications with their patients has always been a cornerstone, a fundamental element of a highly functioning health care system.
- From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. (AMA Ethical Policy, E-1.1.3)

- A physician must always have the ability to freely communicate with his or her patient, providing information to patients about their health and safety, without fear of intrusion by government and/or other third parties. (AMA policy H-5.989)
- Standing against criminal prosecution of physicians for clinical decision-making is essential to ensuring that the patient-physician relationship remains sacrosanct. Physicians should never be subject to criminal prosecution for clinical decisions made based on their professional judgment. Doing so would have a serious detrimental impact on their ability to exercise that judgment and therefore, is contrary to the interests of the public. (AMA policy H-160.946, H-160.954, D-160.999)
- The AMA opposes legislation that infringes on the matter or breadth of information exchanged within the patient physician relationship because of the potential harm it can cause to the health of the individual, family and community.
- Physicians should be free to have open and honest communication with patients about all aspects of health and safety. Physicians should be able to gather any information that can impact the health of their patients and their patients' families.
- The AMA leads efforts in multiple arenas to leave the determination of what is medically necessary treatment where it belongs – in the hands of doctors. Health insurance gatekeepers and finance officers continually find new ways to delay and deny care, and erect barriers to medically necessary care for patients. Doctors are often a patient's only ally in this David vs. Goliath battle that frequently entails mountains of paperwork and endless phone calls. Doctors believe it is a fundamental element of the physician-patient relationship to fight for their patients' needed care to be delivered in a timely manner.

Relevant AMA policy

H-270.959 AMA Stance on the Interference of the Government in the Practice of Medicine

1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:

- A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
- B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
- C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
- D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter. (Res. 523, A-06; Appended: Res. 706, A-13)

H-373.995 Government Interference in Patient Counseling

- (1) Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
- (2) Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
- (3) Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
- (4) Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
- (5) Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
 - A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
 - B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
 - C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
 - D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
 - E. Is the proposed law or regulation required to achieve a public policy goal ? such as protecting public health or encouraging access to needed medical care ? without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
 - F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
 - G. Is there a process for appeal to accommodate individual patients' circumstances?
- (6) Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States. (Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15)

H-5.989 Freedom of Communication Between Physicians and Patients

It is the policy of the AMA:

- (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;

- (2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;
- (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and
- (4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients. (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13)

E-1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

- (a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
- (b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethical guidelines on court-initiated treatment.
- (c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethical guidelines. In such situations, a limited patient-physician relationship exists. (AMA Principles of Medical Ethics: I,II,IV,VIII)

E-1.1.3 Patient Rights

The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

- (a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
- (b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.
- (c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
- (d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
- (e) To have the physician and other staff respect the patient's privacy and confidentiality.
- (f) To obtain copies or summaries of their medical records.
- (g) To obtain a second opinion.

- (h) To be advised of any conflicts of interest their physician may have in respect to their care.
- (i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care. (AMA Principles of Medical Ethics: I,IV,V,VIII,IX)

E-5.5 Medically Ineffective Interventions

At times patients (or their surrogates) request interventions that the physician judges not to be medically appropriate. Such requests are particularly challenging when the patient is terminally ill or suffers from an acute condition with an uncertain prognosis and therapeutic options range from aggressive, potentially burdensome life-extending intervention to comfort measures only. Requests for interventions that are not medically appropriate challenge the physician to balance obligations to respect patient autonomy and not to abandon the patient with obligations to be compassionate, yet candid, and to preserve the integrity of medical judgment.

Physicians should only recommend and provide interventions that are medically appropriate—i.e., scientifically grounded—and that reflect the physician’s considered medical judgment about the risks and likely benefits of available options in light of the patient’s goals for care. Physicians are not required to offer or to provide interventions that, in their best medical judgment, cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care. Respecting patient autonomy does not mean that patients should receive specific interventions simply because they (or their surrogates) request them. Many health care institutions have promoted policies regarding so-called “futile” care. However, physicians must remember that it is not possible to offer a single, universal definition of futility.” The meaning of the term “futile” depends on the values and goals of a particular patient in specific clinical circumstances. As clinicians, when a patient (or surrogate on behalf of a patient who lacks decision-making capacity) request care that the physician or other members of the health care team judge not to be medically appropriate, physicians should:

- (a) Discuss with the patient the individual’s goals for care, including desired quality of life, and seek to clarify misunderstandings. Include the patient’s surrogate in the conversation if possible, even when the patient retains decision-making capacity.
- (b) Reassure the patient (and/or surrogate) that medically appropriate interventions, including appropriate symptom management, will be provided unless the patient declines particular interventions (or the surrogate does so on behalf of a patient who lacks capacity).
- (c) Negotiate a mutually agreed-on plan of care consistent with the patient’s goals and with sound clinical judgment.
- (d) Seek assistance from an ethics committee or other appropriate institutional resource if the patient (or surrogate) continues to request care that the physician judges not to be medically appropriate, respecting the patient’s right to appeal when review does not support the request.
- (e) Seek to transfer care to another physician or another institution willing to provide the desired care in the rare event that disagreement cannot be resolved through available mechanisms, in keeping with ethical guidelines. If transfer is not possible, the physician is under no ethical obligation to offer the intervention.

As leaders within their institutions, physicians should encourage the development of institutional policy that:

- (f) Acknowledges the need to make context sensitive judgments about care for individual patients.
- (g) Supports physicians in exercising their best professional judgment.
- (h) Takes into account community and institutional standards for care.
- (i) Uses scientifically sound measures of function or outcome.
- (j) Ensures consistency and due process in the event of disagreement over whether an intervention should be provided. (AMA Principles of Medical Ethics: I,IV,V)

H-275.937 Patient/Physician Relationship and Medical Licensing Boards

- (1) Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are:
 - a. Open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in his or her care.
 - b. Commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician's personal interests.
 - c. Provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more nor less.
 - d. Avoidance of any conflict of interest or inappropriate relationships outside of the therapeutic relationship.
- (2) The relationship between a physician and a patient is fundamental and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship.
- (3) Any act or failure by a physician that violates the trust upon which the relationship is based may place the physician at risk of being found in violation of the Medical Practice Act.
- (4) The following statement reflects the policy of the (name of state) Board of Medical Examiners regarding the physicians it licenses.
- (5) A (name of state) physician has both medical-legal and ethical obligations to his or her patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients. (BOT Rep. 30, I-98; Reaffirmed: CME Rep. 2, A-08)

Op-eds and reports

<http://www.ama-assn.org/ama/pub/news/letters-editor/2012-05-28-usatoday-dont-legislate-medicine.page>

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www.nejm.org/doi/full/10.1056/NEJMs1209858, *Legislative Interference with the Patient-Physician Relationship*. Steven E. Weinberger, M.D., Hal C. Lawrence III, M.D., Douglas E. Henley, M.D., Errol R. Alden, M.D., and David B. Hoyt, M.D .

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