REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 4-A-09

Subject: Physician Employment by a Nonphysician Supervisee

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Referred to: Reference Committee on Amendments to Constitution and Bylaws (Daniel W. Van Heeckeren, MD, Chair)

At its 2008 Annual Meeting, the House of Delegates (HOD) of the American Medical Association (AMA) adopted Resolutions 5, "Employment Relations," and 13, "Physician Employment by a Physician Extender." Resolution 5 asked that the AMA's Council on Ethical and Judicial Affairs (CEJA) address the ethical implications of physicians working as employees of those whom the physician is required to supervise. Resolution 13 asked our AMA to address the ethical considerations that arise when a physician supervises or collaborates with a midlevel practitioner by whom the physician is employed. Given the resolutions' common concerns regarding ethical boundaries in physicians' relationships with nonphysician practitioners with respect to supervision and employment, CEJA believes these issues can best be addressed in the single report that follows.

CEJA has stated in previous opinions that in any contractual relationship, physicians should be free from outside interference in professional medical matters and should not enter into any arrangement that undermines the physician's ethical obligation to advocate for patient welfare.[1, 2] A broad range of contractual relations exists between physicians and their nonphysician colleagues. The nature of the relationship in turn may create varying degrees of conflict for physicians. For example, as an independent contractor, a physician is entrusted to undertake a specific project but is left free to perform his or her clinical duties and to choose the method for accomplishing these duties. An employee, on the other hand, works in the service of another person (the employer) under an express or implied contract of hire, under which the employer has the right to control the details of the physician's work performance to some extent. The latter employment relationship poses unique conflict of interest challenges for a physician who is responsible for supervising a nonphysician clinician who is also the physician's employer. This relationship in particular is the subject of the following report. CEJA intends to address the more complex topic of collaborative arrangements in a future discretionary report.

CURRENT PRACTICE ENVIRONMENT

Physicians are increasingly working with midlevel practitioners, such as physician assistants and nurse practitioners, to increase access to cost-effective, quality care. In the past decade, the practice environment of nonphysician clinicians has changed dramatically. The number of certified

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nonphysician clinicians reached 200,000 in 2007.[3-5] In addition, state laws and regulations have incrementally expanded both the scope of practice prerogatives of nonphysician clinicians and their autonomy from physicians.[3] As a result, nonphysician clinicians are increasingly assuming "tasks and responsibilities that physicians formerly considered their own."[3]

Different states recognize various degrees of clinical authority for midlevel practitioners, but all within defined levels of primary and specialty care.[3] States have granted nonphysician clinicians the authority, in limited circumstances and in accordance with their training, to diagnose the patient, communicate that diagnosis, assume a degree of responsibility for care, and refer the patient to other clinicians as appropriate.[3] Some states have granted nurse practitioners a level of clinical authority independent of physician involvement. While physician assistants by definition practice under the direction of a licensed physician, some states allow physician assistants to prescribe independent of physician authority, so long as such prescribing is consistent with the physician's overall direction.[3]

Nonphysician clinicians are also beginning to move toward greater ownership roles in health care practices. In some states, midlevel practitioners are legally permitted to own medical practices in whole or in part and to employ physicians.[6-8] Currently this is a relatively rare occurrence. These roles have largely been adopted for practical reasons, such as being able to ensure continued service in rural or underserved areas when a supervising physician moves or retires and leaves his midlevel practitioner in a well-established practice.[9] A physician in a neighboring area may be willing to supervise the nonphysician clinician but not to assume the burden of owning another practice.[6] Alternatively, midlevel practitioners may be offered opportunities to join a practice as partners or shareholders as incentives to recruit them to a physician's practice.[9] Ownership arrangements may range from a minor interest in a corporation that manages a hospital to a majority interest in a small group practice.

These changes are occurring in the context of powerful trends in medicine toward greater measurement, management, and regulation of medical practice. Medical knowledge has been increasingly "systematized" through measurements of medical work, e.g., case mix measures (such as diagnosis related groups), for a variety of managerial purposes, including prospective remuneration.[10] Other managerial strategies have further defined how doctors deliver care at the level of individual patient encounters (e.g., clinical protocols) and process patients through the health care delivery system.[10] Financial and other incentives, as well as state regulations (such as compulsory clinical audits and publication of clinical performance indicators) have also significantly modified clinical practice over the years. In the era of managed health care, therefore, employers and administrators—who may often be nonphysicians—play an increasingly dominant role in what care is provided and how. These past trends have inappropriately undermined, constrained, and curtailed clinical autonomy at the level of individual patient encounters.[10]

Medical practices run by nonphysician clinicians may enhance access to care, especially in medically underserved communities. However, when nonphysicians employ physicians to supervise the employer's clinical practice, they create conditions that can lead to ethical dilemmas for the physician. To the extent that the owner-employer has authority over the physician, the relationship may compromise the physician's judgment and clinical autonomy. Such relationships can create or appear to create tensions between the physician's obligation to put patient care interests above the physician's self-interests including income and employment benefits.

PHYSICIAN SUPERVISION OF MIDLEVEL PRACTITIONERS

Physician relationships with midlevel practitioners are based on mutual respect and trust. Physicians and nonphysician clinicians share an ethical commitment to alleviate illness.[11] This purpose of medicine is common to the ethical codes of physicians, physician assistants, and nurses.[11-13] Physician support for nonphysician colleagues must not undermine the physician's primary duty to a patient's well-being. The central goal of supervision is to ensure patient safety and improve patient care.[14, 15] The physician is accountable to both the patient and the profession of medicine to act in accord with the patient's interests at all times, including when he or she acts as supervisor of midlevel practitioners.

Given their common goals of excellence in patient care, all health care professionals recognize that clinical tasks should be shared and delegated in keeping with each practitioner's training and scope of practice.[13, 16, 17] Midlevel practitioners generally provide wellness care and care for uncomplicated acute disorders and mild chronic conditions.[3] Similarly, while routine aspects of specialty care may be within the scope of care of midlevel practitioners with appropriate training, case management and complex procedures may only be performed by physicians. The physician's greater scope of practice is based on the range and depth of education and training that physicians receive. They retain ultimate professional responsibility for the quality of care that patients receive, even if some aspects of that care may be delivered by nonphysician clinicians.

To a great extent, state laws mandate physician supervision of midlevel practitioners and also delineate the terms of such supervision. A supervising physician accepts full professional and legal responsibility for the medical services provided by a midlevel practitioner under the physician's direction and supervision. In states where physician supervision of nonphysicians is mandated, physician supervisors are held accountable for those they supervise in the form of direct and vicarious liability. These legal standards are intended to protect patients and promote safe, effective practice.[18]

Supervision needs often vary according to the supervisee's experience and level of training.[14] In some states, supervisory requirements are on a sliding scale based on the nonphysician clinician's level of experience.[19, 20] In all cases, a physician is obligated to ensure that the nonphysician clinicians who practice under his or her supervision provide appropriate care within the nonphysician clinician's scope of practice. Practice that is inconsistent with a midlevel practitioner's recognized scope of practice, education, and training can compromise the safety and quality of health care delivered to patients.

Thus, situations in which physicians supervise the clinical practice of a midlevel practitioner who is also their employer can put the physician in an ethically untenable position. To the extent that maintaining the employment relationship with a midlevel practitioner contributes significantly to the physician's livelihood, this can potentially put the physician's personal financial interests at odds with patient care interests.[1, 2] Simultaneously fulfilling the roles of a supervisor and an employee may create real or perceived conflicts regarding professional judgment and clinical care. Being employed by a nonphysician clinician who is in a position to influence one's professional judgment and clinical recommendations can undermine the physician's ability to fulfill this responsibility.

Physician supervisors must be highly sensitive to the potential for erosion of their ability both to practice according to their training and expertise and to honor their primary commitment to the

patient's well-being. Preserving the physician's clinical autonomy is essential for ethically sound practice, even when the physician is not the practitioner actually delivering hands-on care. Any supervisory relationship that may compromise a physician's autonomous clinical judgment undermines professionalism and professional accountability and is therefore inconsistent with the code of professional medical ethics.

Due to the inherent conflicts of the simultaneous roles of employee and supervisor of one's employer it is necessary to avoid any arrangements that require a physician to supervise his or her employer, regardless of the supervisee's level of ownership interest or degree of influence over employment decisions. Because employer status confers broad administrative and financial influence, physicians ethically cannot supervise midlevel practitioners who simultaneously employ them.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

> Physicians' relationships with midlevel practitioners must be based on mutual respect and trust as well as their shared commitment to patient well-being. Health care professionals recognize that clinical tasks should be shared and delegated in keeping with each practitioner's training and scope of practice. Given their comprehensive training and broad scope of practice, physicians have a professional responsibility for the quality of overall care that patients receive, even when aspects of that care are delivered by nonphysician clinicians.
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> When nonphysicians employ physicians to supervise the employer's clinical practice, conditions are created that can lead to ethical dilemmas for the physician. If maintaining an employment relationship with a midlevel practitioner contributes significantly to the physician's livelihood, a physician's personal and financial interests can be put at odds with patient care interests. Similarly, the administrative and financial influence that employer status confers creates an inherent conflict for a physician who is simultaneously an employee and a clinical supervisor of his or her employer.
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> Physicians in such arrangements must give precedence to their ethical obligation to act in the patient's best interest by always exercising independent professional judgment, even if that puts the physician at odds with the employer/supervisor.

(New HOD/CEJA Policy)

Fiscal Note: Staff cost estimated at less than $500 to implement.

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