1.2.10 Political Action by Physicians

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.

(b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.

(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.

(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

AMA Principles of Medical Ethics: I,III,VI

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 5-I-04 Amendment to Opinion 9.025, Collective action and patient advocacy

CEJA Report 9-A-98 Collective action and patient advocacy

1.2.10 Political Action by Physicians

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. *Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However,* they have a responsibility to do so in ways that are not disruptive to patient care. *[new content sets out key ethical values and concerns explicitly]*

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AMA Principles of Medical Ethics: I,III,VI

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 5 - I-04

Subject: Amendment to Opinion E-9.025, "Collective Action and Patient Advocacy"

Presented by: Michael S. Goldrich, MD, Chair

Referred to: Reference Committee F and Amendments to Constitution and Bylaws (Carol S. Shapiro, MD, Chair)

In light of recent physician actions advocating for change to medical liability laws, the Council reviewed its current Opinion on collective action and determined that it should provide guidance that addresses non-employment related matters as well as labor matters. The Council also proposes language to emphasize that physician participation should be voluntary and free from undue pressure from colleagues. Further guidance on the legal risks that may arise from certain forms of collective actions can be obtained from the AMA's General Counsel.

Generally, edits of a current Opinion that simply provide clarification and do not change the substance of guidelines are presented to the House of Delegates in the form of a CEJA Opinion, which is then filed. Because the proposed amendments to current Opinion E-9.025 introduce substantive changes, CEJA wishes to present the edited Opinion to the House of Delegates in the form of a Report, to foster discussion of these changes before it issues the amended Opinion.

RECOMMENDATIONS

The Council recommends that Opinion E-9.025, "Collective Action and Patient Advocacy," be amended as follows and the remainder of the Report be filed.

E-9.025, "~~Collective Action and Patient~~ Advocacy for Change in Law and Policy"

> Physicians may participate in individual acts, grass roots activities, or legally permissible collective action to advocate for change, as provided for in the AMA's *Principles of Medical Ethics*. Whenever engaging in advocacy efforts, physicians must ensure that the health of patients is not jeopardized and that patient care is not compromised.
>
> ~~Collective action should not be conducted in a manner that jeopardizes the health and interests of patients.~~ Formal unionization of physicians, ~~and~~ including physicians-in-training, may tie physicians' ~~interests~~ obligations to the interests of workers who may not share physicians' primary and overriding commitment to patients ~~and the public health~~.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

Physicians should not form workplace alliances with those who do not share these ethical priorities.

Strikes and other collective action may reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences raises ethical concerns ~~is contrary to the physician's ethic~~. Physicians should refrain from the use of the strike as a bargaining tactic. In rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care. Physicians are cautioned that some actions may put them or their organizations at risk of violating antitrust laws. Consultation with legal counsel is advised.

~~There are some measures of collective action that may not impinge on essential patient care. Collective activities aimed at ultimately improving patient care may be warranted in some circumstances, even if they create inconvenience for the management.~~

Physicians and physicians-in-training should ~~take full advantage of the tools of collective action through which to~~ press for needed reforms~~.~~ through the use of ~~I~~informational campaigns, non-disruptive public demonstrations, lobbying and publicity campaigns, and collective negotiation ~~are among the options available which do not limit services to patients~~ or other options that do not jeopardize the health of patients or compromise patient care.

~~Physicians' collective activities should be in conformance with the law.~~ Physicians are free to decide whether participation in advocacy activities is in patients' best interests. Colleagues should not unduly influence or pressure them to participate nor should they punish them, overtly or covertly, for deciding whether or not to participate. (I, III, VI)

Issued December 1998 based on the report "Collective Action and Patient Advocacy," adopted June 1998. Updated December 2004 based on the report "Amendment to Opinion E-9.025, 'Collective Action and Patient Advocacy.'"

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

APPENDIX

The amended Opinion would read as follows:

E-9.025, "Advocacy for Change in Law and Policy"

Physicians may participate in individual acts, grass roots activities, or legally permissible collective action to advocate for change, as provided for in the AMA's *Principles of Medical Ethics*. Whenever engaging in advocacy efforts, physicians must ensure that the health of patients is not jeopardized and that patient care is not compromised.

Formal unionization of physicians, including physicians-in-training, may tie physicians' obligations to the interests of workers who may not share physicians' primary and overriding commitment to patients. Physicians should not form workplace alliances with those who do not share these ethical priorities.

Strikes and other collective action may reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences raises ethical concerns. Physicians should refrain from the use of the strike as a bargaining tactic. In rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care. Physicians are cautioned that some actions may put them or their organizations at risk of violating antitrust laws. Consultation with legal counsel is advised.

Physicians and physicians-in-training should press for needed reforms through the use of informational campaigns, non-disruptive public demonstrations, lobbying and publicity campaigns, and collective negotiation or other options that do not jeopardize the health of patients or compromise patient care.

Physicians are free to decide whether participation in advocacy activities is in patients' best interests. Colleagues should not unduly influence or pressure them to participate nor should they punish them, overtly or covertly, for deciding whether or not to participate. (I, III, VI)

Issued December 1998 based on the report "Collective Action and Patient Advocacy," adopted June 1998. Updated December 2004 based on the report "Amendment to Opinion E-9.025, 'Collective Action and Patient Advocacy.'"

CEJA Report 9 – A-98
Collective Action and Patient Advocacy

INTRODUCTION

Interest in organized labor has grown steadily among physicians over the past several years with the rapid emergence of employed doctors and their increasing frustration with managed care. The formation of unions has become a topic of spirited discussion within medical societies and physician groups across the country. It has also become the focus of national media within recent years.

At the 1997 Annual Meeting, the AMA Board of Trustees issued Reports 41 and 42, which provide information on the subject of unionization and call for the creation of a special division of representation within the AMA which will assist in collective negotiations on behalf of physicians and patients. The House of Delegates also adopted policy at the 1997 Annual Meeting to enable this division to move forward vigorously to help state and county medical societies in representing physicians.

In this report, the Council considers the ethical implications of collective action on the part of physicians and offers some guidelines in this area.

CLIMATE OF UNREST

A sense of powerlessness and disenchantment is pervasive in medicine today. Many physicians seek representation through collective action as a way of voicing their anger over the intrusive control exercised by their employers—in particular, managed care systems that continue to aggressively dictate payment and coverage terms in their contracts with physicians. Physicians have demonstrated frustration at their loss of decision-making powers and their lack of control over the quality of patient care. They argue that it is increasingly difficult for them to serve their patients' interests in an environment which is hostile to these interests. Increased patient loads (and subsequently, less time to spend with each patient); late payments; gag clauses; complicated referral processes meant to discourage costly treatment options; and staff shortages have been offered as only a few of the elements that contribute to sub-optimal working conditions.[1] Physicians have also expressed concern that these systems provide no due process through which their grievances can be heard. The duress created by these developments has led some physicians to organize collectively to seek solutions.

In the case of physicians-in-training, their frustrations are compounded by a predicament of "double jeopardy." Work conditions that threaten patient care can also mean that they suffer in terms of training and education.[2] Moreover, internship and residency programs are subject to hospital certification, rendering house staff vulnerable to disciplinary measures from administration.

According to the Council on Medical Service, between 1983 and 1995, the proportion of non-federal physicians who are employed rose from 24.2% to 45.4%.[3] An estimated 20,000 of these employed physicians have formed collective bargaining units sanctioned by the National Labor Relations Board.[4] Participation in collective action may allow these physicians to respond to the economic leverage of health care plans with some leverage of their own.

PHYSICIANS AS EMPLOYEES

With nearly half of American physicians currently working as employees of medical groups, hospitals, or HMOs or other plans, there has been growing acceptance of collective bargaining as an appropriate option for physicians. Historically physicians have been considered independent contractors with claims of self-governance—any collective action on their part would have been prohibited under antitrust laws that bar

individual competitors from banding together to set prices or working conditions. Physicians who are employees, however, fall within the labor exemption to the antitrust laws. Under the protection of the National Labor Relations Act of 1935, physicians may engage in collective bargaining with employers.[5]

In addition, physicians-in-training—represented by the Committee of Interns and Residents (CIR)—recently filed a petition to challenge the 1976 National Labor Relations Board ruling that house officers in private hospitals are not entitled to collectively bargain because they are primarily students.[6] The notion of house staff as employees has also grown more prevalent.

ETHICAL CONSIDERATIONS

Physicians have a fiduciary obligation to hold their patients' interests paramount. Their roles as employees should neither detract from their roles as professionals nor alter their intrinsic and dominant commitment to serve others in need of their special knowledge and skills.

In light of these professional commitments, collective bargaining should not be sought in a manner that jeopardizes the health and interests of patients. Collective action should never be conducted in a way that preempts the patient's or public's goals in favor of the physician's own.

Furthermore, formal unionization of physicians and physicians-in-training may tie physicians' interests to the interests of workers who do not share the physicians' primary and overriding commitment to patients and the public health. Physicians should not form workplace alliances with those who do not share these ethical priorities.

WITHHOLDING MEDICAL SERVICES AS A BARGAINING TACTIC

The AMA has long affirmed, in Policy H-405.988, the medical profession's tradition of "not withholding medical services or performing any act that will interfere with the public welfare as a bargaining mechanism."[7] The moral commitment of medical professionals and professionals-in-training is to their patients' needs above their own. This renders the strike unavailable as a means to even the most public-spirited of ends.

A strike is a coercive device on the part of workers who fear that administrators would otherwise be complacent and unconcerned. In the health sector, some argue that a strike might be justified by the argument that it would do greater good for patients and the public in the long run. While it remains possible that strike-threat power can further long-term objectives such as improved patient care, strikes are by their very nature disruptive. No matter how well-coordinated or well-prepared health facilities may be, strikes reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences is contrary to the physician's ethic.

One economist maintains that strikes follow the rule that victory is "to the strong, not the just" and usually, "the non-combatants suffer most."[8] The cost of strikes can fall most heavily on non-parties to a dispute. The right to protest for one's patient does not warrant sacrificing patient welfare, even on a temporary basis. Those who strike for the sake of patients lose credibility in the eyes of the profession and the public by momentarily threatening the very end they seek.

However there are several activities that may not impinge on essential patient care and that may ultimately improve patient care. In this context, activities that slow productivity and create inconvenience to management might be warranted in some circumstances. A concerted suspension of paperwork is one example that has been given as a potentially successful option of last recourse.[9] Another more controversial strategy is a well-circumscribed slowdown of elective non-urgent care.

In general, the success of physicians' collective action and collective bargaining does not depend on the ability to strike. Physicians and physicians-in-training are capable of using a variety of approaches that do not limit services to patients—e.g. informational pickets, non-disruptive public demonstrations, lobbying and publicity campaigns, collective negotiation. These can all bring political and economic pressure to serve the goals of patient care and health policy.

PATIENT ADVOCACY

Principle VII of the Principles of Medical Ethics requires that physicians "recognize a responsibility to participate in activities contributing to an improved community." Indeed physicians should strive to identify, inform themselves of, and speak out on health care matters.[10] Collective action may be one of many ways physicians can fulfill their special political responsibilities, at least on a local institutional level. It may also enable physicians to take a more aggressive role as advocates for their patients.

Physicians have a spectrum of means through which to press for needed reforms, such as the Accreditation Council for Graduate Medical Education for residents or professional societies and political action committees for physicians. Physicians and physicians-in-training who wish to advance their patients' or the public's interests should take full advantage of the tools of collective action which they have available to them.

RECOMMENDATIONS

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

1) Collective action should not be conducted in a manner that jeopardizes the health and interests of patients.

2) Formal unionization of physicians and physicians-in-training may tie physicians' interests to the interests of workers who may not share physicians' primary and overriding commitment to patients and the public health. Physicians should not form workplace alliances with those who do not share these ethical priorities.

3) Strikes reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences is contrary to the physician's ethic. Physicians should refrain from the use of the strike as a bargaining tactic.

4) There are some measures of collective action that may not impinge on essential patient care and may ultimately improve patient care. In this context, activities that slow productivity and create inconvenience to the management might be warranted in some circumstances.

5) Physicians and physicians-in-training should take full advantage of the tools of collective action through which to press for needed reforms. Informational pickets, non-disruptive public demonstrations, lobbying and publicity campaigns, and collective negotiation are among the options available which do not limit services to patients. (Principle VII)

6) A physician's union activities should be in conformance with the law. (Principle III)

REFERENCES

1. Adelson A. Physician, unionize thyself: doctors adapt to life as HMO employees. *NewYork Times*. April 7, 1997, p. D1, 22.

2. Hoffman L. Housestaff activism: the emergence of patient-care demands. *J Health Polit Policy Law*. 1982;7:421-439.

3. Council on Medical Service, American Medical Association. Report 9-I-96, "Trends in physician practice consolidation." In: *Proceedings of the House of Delegates of the American Medical Association, 50th Interim Meeting.* Chicago: American Medical Association; 1996:259-267.

4. Larkin H. "Illinois doctors organize to protect care; AMA backs it." *American Medical News*. November 3, 1997:1, 22-23.

5. National Labor Relations Act. 29 USC *et seq* (1982).

6. Jaklevic MC. Physicians find power in unions. *Modern Healthcare.* 1997:99-106.

7. House of Delegates, American Medical Association. Policy H-405.998, "Opposition to the concept of withholding medical services." In: *Policy Compendium.* Chicago: American Medical Association; 1997:546.

8. Hutt WH. The Theory of Collective Bargaining. London, England: Institute of Economic Affairs Press; 1975:87-88.
9. Physicians of Nevada Physicians Union orchestrated a "white-in" at Valley Hospital in response to a mandate by administrators requiring one afternoon a week of chart review. The physicians invited all emergency room patients to take a bed and proceeded to provide care for everyone—without completing any of the necessary paperwork. The administration quickly relented to the union's terms. The job action achieved the desired effect without depriving patients of medical care. In: Budrys G. *When Doctors Join Unions*. Ithaca, NY: Cornell University Press; 1997.

10. Council on Ethical and Judicial Affairs, American Medical Association. Principles of Medical Ethics. In: *Code of Medical Ethics*. Chicago: American Medical Association; 1996:xiv.