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3 Title: Physician Antiretaliation, Due Process, and Indemnification Rights
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5 Introduced by: David Whalen, MD, for the Grand Traverse-Leelanau-Benzie County
6 Delegation
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8 Original Author: Leah Davis, DO
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10 Referred To: Reference Committee B
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12 House Action: **APPROVED**
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15 Whereas, Michigan law regarding the corporate practice of medicine prohibits “a for-profit
16 entity, either a corporation or a limited liability company, from practicing medicine or employing a
17 physician to provide professional medical services” but excludes non-profit organizations, and
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19 Whereas, a decreasing percentage of physicians maintain ownership in their medical
20 practices, and
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22 Whereas, an increasing percentage of physicians in Michigan are now employed directly or
23 indirectly by hospitals, health systems, medical service organizations affiliated with health systems
24 which may allow merely notional physician leadership, or contracted through large contract
25 management groups, and
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27 Whereas, consolidation of healthcare corporations with restrictive non-compete clauses in
28 physician employment contracts combined with high average educational debt of medical school
29 graduates/new physicians has brought about conditions of oligopsony (and even monopsony in
30 some regions) in the Michigan physician labor market, in which physicians may feel compelled to
31 remain in employment or contractual obligation with an entity which may be attempting to direct
32 or control their medical autonomy, and
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34 Whereas, in some geographic locations, third party contractors are taking advantage of
35 these factors and eliminating the “due process” provisions from employment contracts, and
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37 Whereas, current legislation prohibiting workplace retaliation might be circumvented by
38 hospitals, health systems, and medical service organizations which may wish to unfairly remove a
39 physician with whom they do not agree by simply requesting that the contract management group,
40 for which the physician is directly employed, no longer use the physician to staff their facility, and
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42 Whereas, nonphysician practitioners (NPPs) (e.g., nurse practitioners, physician assistants,
43 certified registered nurse assistants, etc.), pharmacists, and other health professionals may be
44 delegated through legislation to perform certain duties and functions which may overlap with the
45 duties and functions of an independent licensed physician, and
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47 Whereas, corporate entities which employ or contract with physicians may require
48 acceptance of collaborative agreements with NPPs as a duty of employment, without the
49 physician’s input regarding quality assessment, hiring or firing, staffing ratios, or the provision of

50 time or compensation to adequately collaborate regarding the medical care delegated to NPPs,
51 and

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53 Whereas, there have been some cases of termination of physicians based on accusations
54 that were not clearly substantiated and for which the physician was not afforded the opportunity of
55 a fair hearing or peer review through the appropriate medical staff processes; therefore be it
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57 RESOLVED: That MSMS (1) continue to assess the needs of employed physicians, ensuring
58 autonomy in clinical decision-making and self-governance; (2) promote physician collaboration,
59 teamwork, partnership, and leadership in emerging health care organizational structures, including
60 but not limited to hospitals, health care systems, medical groups, insurance company networks and
61 accountable care organizations, in order to assure and be accountable for the delivery of quality
62 health care; (3) advocate for the rights of physicians against employer retaliation, including unfair
63 or discriminatory termination of employment or contractual obligation for conscious objection
64 and/or conscious refusal to participate in any activity that the physician judges to be unethical or
65 unsafe for patients; and (4) advocate for the physician's authority to practice medicine based on
66 medical judgment, conscience, ethics, morals, or good faith obligation toward patients to a non-
67 physician or corporate entity; and be it further
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69 RESOLVED: That MSMS adopt policy and advocate (1) to ensure physicians on staff receive
70 written notification when their license is being used to document supervision of non-physician
71 practitioners; (2) that physician supervision should be explicitly defined and mutually agreed upon;
72 (3) that advanced notice and disclosure be provided to physicians before they are hired or as soon
73 as practicably known by provider organizations and institutions that anticipate physician
74 supervision of non-physician practitioners as a condition for physician employment; (4) that
75 organizations, institutions, and medical staffs that have physicians who participate in supervisory
76 duties for non-physician practitioners have processes and procedures in place that have been
77 developed with appropriate clinical physician input; (5) that physicians have the right to object to
78 or refuse to allow their license to be used to document supervision of non-physician practitioners
79 without fear of retaliation; (6) that physicians be able to report professional concerns about care
80 provided by the non-physician practitioners to the appropriate leadership with protections against
81 retaliation; and (7) should be indemnified at the organizations' and institutions' expense from
82 malpractice claims and other litigation arising out of the supervision function.
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85 WAYS AND MEANS COMMITTEE FISCAL NOTE: \$12,000-\$24,000

Relevant MSMS Policy:

Non-Physician Practitioner Use Rules

MSMS supports daily physician supervision of all non-physician practitioners who provide care to hospitalized patients as documented by a signature.

Relevant AMA Policy:

Supervision of Non-Physician Practitioners by Physicians D-35.978

Our AMA will advocate: (1) to ensure physicians on staff receive written notification when their license is being used to document supervision of non-physician practitioners; (2) that physician supervision should be explicitly defined and mutually agreed upon; (3) for advanced notice and disclosure to the physician before they are hired or as soon as practicably known by provider organizations and institutions that anticipate

physician supervision of non-physician practitioners as a condition for physician employment; (4) that organizations, institutions, and medical staffs that have physicians who participate in supervisory duties for non-physician practitioners have processes and procedures in place that have been developed with appropriate clinical physician input; and (5) that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections against retaliation.

Supervision and Proctoring by Facility Medical Staff H-375.967

Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:

- (1) Physicians serving as medical staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function.
- (2) Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.
- (3) AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.
- (4) The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.
- (5) The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.
- (6) The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.
- (7) Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.
- (8) Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcribed by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.
- (9) Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports.

Scopes of Practice of Physician Extenders H-35.973

Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

Principles for Revision of the Medical Staff Section of The Joint Commission "Accreditation Manual for Hospitals" H-220.990

The AMA supports adherence to the following principles as the basis for any revision of the Medical Staff Section of the "Accreditation Manual for Hospitals": (1) continued use of the term "Medical Staff" in the title of the chapter and throughout the Manual; (2) deletion of any specific reference to limited licensed practitioners without precluding such practitioners from having hospital privileges consonant with their training, experience and current competence, if approved by the normal credentialing process; (3) consideration of qualified limited licensed practitioners in accordance with state law, and when approved by the executive committee of the medical staff, by the governing board, and when their services are appropriate to the goals and missions of that hospital, taking into account the training, experience and current clinical competence of the practitioners; (4) provision that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the Medical Staff Bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (Doctors of Medicine or Doctors of Osteopathy) of the active medical staff in the hospital; (5) assurance that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (Doctors of Medicine or Doctors of Osteopathy); and (6) assurance that the

continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians.

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.

Fair Process for Employed Physicians H-435.942

1. Our AMA supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity.
2. Our AMA will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace.