REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-I-22

Subject: Amendment to Opinion 10.8, "Collaborative Care"

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

---

Recent years have seen the rise of nonphysician practitioners (e.g., nurse practitioners, physician assistants, midwives) as a growing share of health care providers in the United States. Moreover, nonphysician practitioners have gained increasing autonomy, authorized by state governments (e.g., legislatures and licensing boards) in response to the lobbying from professional associations, as part of an effort to ameliorate provider shortages, and in response to rising health care costs. Expanded autonomy has increased the interactions of independent nonphysician practitioners and physicians in care of patients. Increasingly nonphysician practitioners are seeking advanced training that results in a doctorate degree, such as "Doctor of Nursing." Such terminology sometimes results in misconception or confusion for both patients and physicians about the practitioner's skillset, training, and experience.

The following is an analysis of the ethical concerns centering on issues of transparency and misconception. In recognition of the growing relevance of the issue, the Council brings this analysis on its own initiative, offering an amendment to the AMA *Code of Medical Ethics* Opinion 10.8 Collaborative Care.

DESCRIPTION OF NONPHYSICIAN PRACTITIONERS

The term "nonphysician practitioners" denotes a broad range of professionals including nurse practitioners, physician assistants, midwives, doulas, pharmacists, and physical therapists. There are "multiple pathways" for one to become a nonphysician practitioner, the most common is a nurse earning a "master's degree or doctoral degree in nursing" after initial completion of a bachelor's degree [1]. However, the skill sets and experience of nonphysician practitioners are not the same as those of physicians. Hence, when a nonphysician practitioner identifies themself as "Doctor" consistent with the degree they received, it may create confusion and be misleading to patients and other practitioners.

PATIENT CONFUSION AND MISCONCEPTION

Patient confusion and misconception about provider credentials is a significant concern. Data suggest that many patients are not sure who is and who is not a physician. For example, 47% of respondents in one survey indicated they believed optometrists were physicians (10% were unsure), while some 15% believed ophthalmologists are *not* (with 12% being unsure) [2]. Nineteen percent

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to 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.

of respondents to the same survey believed nurse practitioners (NPs) to be physicians, although 74% identified them as nonphysicians.

Meanwhile, the range of professional titles of various NPs is wide and the issue is compounded by the fact that many NPs hold doctorate degrees [3]. While the PhD in nursing degree is the oldest and most traditional doctorate in the nursing profession, having its roots in the 1960s and 70s [4], Al-Agba and Bernard note how in "recent years, an explosion of doctorates in various medical professions has made the label of 'doctor' far less clear", a common example being that of the of the "Doctor of Nursing Practice" (DNP) [3]. The DNP, a professional practice doctorate (distinct from the research-oriented PhD), was first granted in the U.S. in 2001. As of 2020, there are now 348 DNP programs in the U.S. [3]. Critics argue that the rise of DNP programs is not about providing better patient care, but is rather a "political maneuver, designed to appropriate the title of 'doctor' and create a false sense of equivalence between nurse practitioners and physicians in the minds of the public" [3].

The problem of identification has been recognized by some states where NPs with a doctorate are only allowed to be "addressed as 'doctor' if the DNP clarifies that he or she is actually an NP" and some jurisdictions require NPs without a doctorate to have special identification that "unambiguously identifies them" [5]. From an ethical standpoint, NPs have a duty as do all health care practitioners, including physicians, to be forthright with patients about their skill sets, education, or training, and to not allow any situation where a misconception is possible. Ambiguous representation of credentials is unethical, because it interferes with the patient's autonomy, as the patient is not able to execute valid informed consent if they misconstrue the provider. For example, a patient may only want a certain procedure done by a physician and then assent to an NP performing the procedure, under the mistaken belief that the NP is a physician. However, such an assent to the medical procedure is neither a valid *consent* nor an adequately informed *assent*, as the patient's decision is founded on a flawed basis of key information, i.e., the nature and extent of the practitioner's skill set, education, and experience.

GUIDANCE IN AMA POLICY AND CODE OF MEDICAL ETHICS

AMA House Policy and the AMA *Code of Medical Ethics* respond to and recognize issues of transparency of credentials and professional identification. However, the *Code* could be modestly amended to offer specific guidance regarding transparency in the context of team-based care involving nonphysician practitioners.

House Policy

H-405.992 – "Doctor as Title," states:

> The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title ""Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

D-405.991 – "Clarification of the Title "Doctor" in the Hospital Environment," states:

> Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD,

> DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

H-405.969 – "Definition of a Physician", states:

> … a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
>
> AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "nonphysician" and define the nature of their doctorate degree.

Code of Medical Ethics

The Code already addresses transparency in context of residents and fellows. Opinion 9.2.2, "Resident & Fellow Physicians' Involvement in Patient Care," possesses some language regarding transparency and identification where it states:

> When they are involved in patient care, residents and fellows should:
>
> (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care.

In the context of a team-based collaborative care involving nonphysician practitioners, Opinion 10.8, "Collaborative Care" is the most relevant *Code* opinion. It gives guidance on the collaborative team-based setting, where a mix of health professionals provide care. However, Opinion 10.8 lacks guidance on the transparency of identification and credentials, ultimately leaving the *Code* silent on the issue of transparency in the context of team-based collaborative care. Hence, amendment to Opinion 10.8 is warranted.

RECCOMENDATION

In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion 10.8, "Collaborative Care," be amended as follows and the remainder of this report be filed:

> In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, ~~protecting the integrity of the patient-physician relationship,~~ sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.
>
> Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to healing relationships between patients and physicians or nonphysician practitioners, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient's care.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As clinical leaders within health care teams, physicians individually should:

(a) Model ethical leadership by:

(i) Understanding the range of their own and other team members' skills and expertise and roles in the patient's care
(ii) Clearly articulating individual responsibilities and accountability
(iii) Encouraging insights from other members and being open to adopting them and
(iv) Mastering broad teamwork skills

(b) Promote core team values of honesty, discipline, creativity, humility and curiosity and commitment to continuous improvement.

(c) Help clarify expectations to support systematic, transparent decision making.

(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.

(e) Communicate appropriately with the patient and family, ~~and~~ respecting the~~ir~~ unique relationship of patient and family as members of the team.

(f) Assure that all team members are describing their profession and role.

As leaders within health care institutions, physicians individually and collectively should:

(~~f~~g) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

(~~g~~h) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(~~hi~~) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

(j) Promote a culture of respect, collegiality and transparency among all health care personnel.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

REFERENCES

1. Government Accountability Office. *Healthcare Workforce: Views on Expanding Medicare Graduate Medical Education Funding to Nurse Practitioners and Physician Assistants,* 2019. Available at: https://www.gao.gov/assets/710/703372.pdf?fbclid=IwAR1-3D5tOArzcS6lLRkMDT6wIksFyX3-yaw75SXOSP55YgOIuN4SyBhZhEQ. Accessed March 5, 2022.
2. American Medical Association. *Truth in Advertising Survey,* 2018. Available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/tia-survey_0.pdf. Accessed March 5, 2022.
3. Al-Agba N & Bernard R. *Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Irvine, CA: Universal Publishers, 2020.
4. Lindell D, Hagler D, Poindexter K. PhD or DNP? Defining the Path to Your Career Destination. American Nurses Today. 2017;12(2):36-39.
5. Zand MB. Nursing the primary care shortage back to health: how expanding nurse practitioners autonomy can safely and economically meet the growing demand for basic health care. *J. Law & Health.* 2011;24(2):261-284.