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COMMENTARY

Who Speaks For Today's Physicians?

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Who speaks for doctors these days? The answer was simple 100 years ago. The AMA spoke for the nation's physicians and concurrently spoke to the nation's desire for quality healthcare. In 1908 the AMA's Council of Medical Education proposed guidelines for what became the Flexner Report in 1910. The Flexner report served as the model for American and Canadian medical education for a century. It also placed the AMA in the forefront of healthcare and made the AMA the premier speaker for our nation's physicians.

Much has changed.

The AMA's position in health care has been radically altered. While the AMA refers to itself as the "House of Medicine," its power and scope have been reduced from that of a "mansion" to a "bungalow." Here, I review those forces and choices in the past century that have led to a redistribution of power between medical professional associations and societies, numerous healthcare enterprises (including insurance companies and hospitals), and various branches of federal and state government and practitioners. I also propose responses to the new and rapidly changing medical landscape to ensure that physician practitioners have appropriate input.

In the years following publication of the Flexner Report, the AMA proposed and assisted in implementing a number of actions that have had a major impact on the focus, organization, and practice of medicine. These included support for the establishment of these agencies (among others):

- The Federation of State Licensing Boards (FSLB)
- The American Board of Medical Specialties (ABMS)
- The Liaison Committee for Medical Education (LCME)
- The Liaison Committee for Graduate Medical Education (LCGME), which subsequently became the Accreditation Council for Graduate Medical Education (ACGME).

In Washington, the AMA was seen as a powerful advocate for its physician members and powerful determiner of healthcare policy.

Diverse forces have led to the decline in AMA authority to speak for the profession. They include the growth of specialization, which has led to an erosion of its members. In political discussions about healthcare, a war chest for lobbying and members equals power. The AMA has seen reductions in both.

With the growth of specialization, individual physicians began to choose between belonging to medical specialty societies or the AMA and its affiliate state medical societies.

AMA membership peaked in 1960; at that time, 74.5% of physicians were members.¹ Today, fewer than 20% of physicians are AMA members. In contrast 60% of psychiatrists in the US are members of the American Psychiatric Society.

Although the AMA has no direct role in the governance of medical specialty societies, it maintains a connection to these societies through its House of Delegates. These societies may send voting delegates to the AMA House of Delegates. In recent years medical specialty society membership has also declined. These societies now face competition from subspecialty societies. Additionally young physicians are less likely to belong to professional organizations than their more senior colleagues.

The AMA once played a central role in developing and implementing policy in many of the organizations it created. Today its role in these and other medical organizations is either reduced or inconsequential. More importantly, its Boards and Councils have become essentially self-perpetuating and have limited or no direct input from organizations that represent practitioners. This absence of diverse broad-based input from practitioners may adversely effect the decision making of these Boards. For example the ABMS developed Maintenance of Certification (MOC) policies both to assess and promulgate activities to maintain physician competence. Some assert that these policies do neither and thus not only do not aid physicians but also may also fail to serve the needs of society.²

Concurrent with these changes in medicine's self-governance is the expansion of government involvement at the local, state, and federal levels in healthcare as manifested in Medicare and Medicaid, the National Institutes of Health, the FDA, as well as other federal government agencies. The federal government is now the major source of funding and policy determination for American healthcare. The recent passage of the Accountable Care Act has further involved the federal government in the direction of health care. These changes have occurred as the AMA's power at the national level has declined.

In dealing with the federal government the AMA has obtained mixed results. In a number of areas, such as the development and maintenance of CPT codes, the AMA has retained a significant interest. After having opposed federal initiatives from social security to Medicare, the AMA supported key aspects of healthcare reform. This effectively gave the AMA a place at the healthcare policy table along with a number of other healthcare players.

But its place is now significantly reduced as it deals with growing federal involvement in all areas of healthcare practice as other major players in healthcare such as the American Hospital Association, the insurance lobby and others exercise their political power. Yet on the federal level and in issues that engage federal agencies and federal legislation, it is likely even with its reduced influence, decision makers believe the AMA still speaks for today's doctors.

Because of its reduced influence and with growing incursions on medical practice, physicians must ask what organizations now speak for us. Specialty medical associations do, though on broad legislative and regulatory issues they have had limited power. On special issues related to their specialty, however, they can assert authority and bring about change. The American Psychiatric Association (APA) did this in fighting for and in obtaining mental health parity legislation.

The most critical role for medical specialty associations may be to represent their members in areas where our society allows the profession to establish its own rules. These include areas of medical

education and in Board Certification. Medical specialty societies must address the American Board of Medical Specialties to ensure that the ABMS standards of initial certification and Maintenance of Certification meaningfully address physician competence.

Specialty societies must also ensure that the procedures for maintenance of certification relate to the actual practice of medicine. In residency education, these societies must ensure that training program standards prepare residents for actual practice of medicine in their specialty. This will require a more active involvement by these societies in establishing professional educational training standards. These initiatives by specialty societies relate to physician professional self-governance.

To make these boards and councils that relate to the practice of medicine more effective, I propose that the members of the Boards or councils must spend between 25% to 50% of their time in clinical practice. If you do not practice, how can you know what the issues are in contemporary medical practice?

These needed reforms will allow practitioners to assert an active role in professional self-governance. The reforms would aid in ensuring the competence of practitioners and our service to society. But these essential actions may be of limited impact on physicians and healthcare as our nation struggles to develop major fiscal reform. Reform of funding our nation's healthcare and social support systems is likely to occur in the coming years.

The US cannot continue to rely on China to buy our bonds to fund critical federal programs. We also cannot afford to spend nearly twice as much to fund our healthcare system as do other industrialized countries without evidence of discernable better healthcare outcomes.

In Washington every medical or healthcare group as well as every interest group has hired the best lobbyists they can afford to urge the government to accept their vision of the future. For practitioners to have a say in what will be the political equivalent of a street brawl, all physician groups must first coalesce and then develop a mutually agreed on plan for reforming healthcare in US. This plan must be presented to society at large and to the administration and congress. To paraphrase Benjamin Franklin. . . if physicians do not hang together at this stage of negotiations, we shall assuredly all hang separately as others take change of healthcare reform.

This is a critical time for American Medicine. The reforms that will occur will shape healthcare and medical practice for decades. We must ask our leaders to lead and represent us.

References

1. American Medical Association Archives. Physician Membership, Chicago: American Medical Association. 2009.
2. Weissman S. Does maintenance of certification ensure maintenance of competency? Psychiatric Times. 2011. <http://www.psychiatrictimes.com/display/article/10168/1773715>.